the Canadian Nurse

VOLUME 57 • NUMBER 5

MONTREAL

MAY 1961

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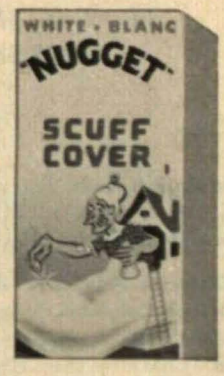

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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Between Ourselves

Dotted far and wide over the rolling countryside and into the mountainous areas that give form to the province of Alberta lie some 1200 communities. They range in size from Edmonton, the largest, to tiny collections of scattered homes with sometimes miles between neighbors. Every one of those places contains *people* — people who have health problems; people whose only contact with modern health facilities may be an occasional visit from a public health nurse; people who may have to travel many miles to reach the nearest hospital, leaving their loved ones far behind.

It is against this backdrop that the Alberta Association of Registered Nurses and its president, DOROTHY JUNE TAYLOR our guest editor, studies a big problem. How best can nursing service be provided for such a widely scattered population? Many small rural hospitals are there to provide for the possible patients but where are the nurses to staff them?

Mrs. Taylor is familiar with life on the prairie. Born in Saskatchewan, she received her early education in Hanna, Alta., graduating from the Royal Alexandra Hospital in Edmonton. Her professional life has been devoted to the care of children. She is currently assistant director of pediatrics at R.A.H.

* * *

Several of the provincial nurses' associations have adopted the pattern of arranging for a "study day" immediately preceding their annual meetings. This provision of an opportunity for convention delegates to meet for the discussion of current issues and problems is very worthwhile. Employing bodies recognize that it is an educational experience and seldom object to the extra day's absence for their staff. Members from a distance appreciate the fact that there is no added expense excepting the extra night's accommodation. The enthusiasm with which these study day programs are received, the earnestness with which prepared papers are evaluated and discussed, the give-and-take of personal opinions, prove the value of this extension of convention planning.

From time to time the *Journal* is able to publish some or all of the formal papers presented during one of these study days. This month we are featuring a portion of the addresses given at the day-long session arranged by the Association of Nurses of the Province of Quebec last year. They present some views respecting nursing service. Other papers from the same program that deal more especially with nursing education will be published in our next issue.

One point in connection with these papers is worthy of particular mention — all of the speakers were local people. It is true that some of them were members of university faculties who, you might rightly claim, are accustomed to giving lectures and so should be able to provide valuable addresses. But please note. We said that *some* were from the university milieu. There are a large number of very capable speakers in every provincial nurses' association who are not in university work. So often when a program is being planned there is a feeling that the principal speakers must be from somewhere else. "They will bring us some new ideas." You would be surprised, perhaps, to find how many stimulating ideas can be developed by your own members — and it is a lot less expensive than bringing in an outside speaker!

* * *

There were many interesting items presented for the consideration of the members of the CNA Executive Committee at the meeting held in Ottawa in February. News of the new alignment of responsibility in our National office is included in The World of Nursing section. There, too, you can read of the presentation made to the National office by a former general secretary. Elsewhere in this issue you will find our summarization of the very interesting reports of provincial association activities that are prepared for presentation to the Executive Committee by the ten provincial executive secretaries. We wish it were possible to share the full reports with you for they make wonderful reading.

A new catalogue of 16 mm. sound motion pictures produced by Smith Kline & French Laboratories has been released. The listing includes 31 films, 16 of which are available to professional audiences only. The catalogue provides a description of each film, including the length of viewing time. All films are available on a free-loan basis. Catalogues may be obtained from local representatives of SK & F or the Medical Film Center, 1500 Spring Garden Street, Philadelphia, Pennsylvania.

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By Dorothy R. Marlow, R.N., Ed.D., Assistant Professor of Pediatric Nursing, University of Pennsylvania School of Nursing; and Gladys Sellew, R.N., Ph.D., formerly Professor of Nursing of Children, University of Maryland School of Nursing. About 896 pages with 277 illustrations. *New — Just Ready!*

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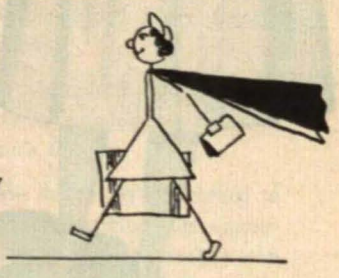

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Random Comments

Dear Editor:

I am very pleased with the self-binders for the Canadian Nurse Journal. There is one question that I have not solved satisfactorily — there is no space for the index. Where do the readers put them for ready reference?

G. M. INNES BROWNE, British Columbia

¶We suggest you glue it to the back cover of the December issue. Ed.

Dear Editor:

At the end of the month my subscription to the Journal, through The Canadian Nurse Award, expires. The magazine is a very helpful textbook and the articles are presented in an interesting way.

I was surprised at how much I could contribute in clinics even though I had read some of the articles many months previously.

Enclosed please find a money order for one-year's subscription.

JOYCE BLACKBURN, Ontario

Dear Editor:

Many thanks for the copy of the February issue.

First of all, as a printer, I would like to say how surprised I was to see the beautiful layouts and arrangements of your magazine, and the excellent reading material which you give to your readers.

I have already read most of the articles in the magazine, and found some of them of extreme interest, even to one outside the nursing profession. I think that the Canadian nurses have every reason to be very proud of their publication.

With very sincere thanks for the honor of publishing my article in both editions of the Journal.

MICHAEL JOSEPH TROY, C.S.Sp., Ontario

Dear Editor:

Is it possible for a nurse (not certified) to subscribe to *The Canadian Nurse?* I have nursed for 20 years in England and Canada, in hospitals and private homes. My pet is geriatrics but I love any type of nursing. My R.N. friends lend me their copies of *The Canadian Nurse* but of course they want them back. I was particularly interested in the story "The Nurse and Parkinson's Disease" in a recent issue, having just been on private duty with a patient who has Parkinson's disease. Also, several years ago I

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helped to take care of a lady with Parkinson's. The same sort of thing happened to her, as in the story, one nurse in particular often discussed her case in her presence and talked about her as though she were senile. The patient in question was a well educated and very sensitive person, and I grew very fond of her.

My 15-year-old daughter has hopes of going into nursing when she has finished high school and I wonder if you can suggest some literature on the subject for her.

KATHLEEN HAY, Ontario

¶*Anyone who wishes to subscribe to The Canadian Nurse may do so. Send your name, address and the appropriate amount of money (see Subscription rates, located below the Table of Contents in each issue) to the Circulation Manager, Miss Winnifred MacLean.*

For literature re: nursing as a career, write to the: Canadian Nurses' Association, 74 Stanley Avenue, Ottawa, or the Registered Nurses' Association of Ontario, 33 Price Street, Toronto 5. Ed.

Dear Editor:

It is always a joy to see *The Canadian Nurse* in San Francisco.

I was greatly shocked by the report of the sudden death of Miss Gertrude Hall. I remember her visit and her interest while I was setting up the Medical Center at Chateau Lake Louise in 1952; that first of three seasons I was senior resident nurse.

DOROTHY (BARBER) MOLINA, California

Dear Editor:

I would like to know if you know of any place where I can get *my journals bound.*

At this time I would like to tell you how much I enjoy reading *The Canadian Nurse.* I particularly liked the articles on "Comprehensive Nursing Care" and "What is Real Nursing? — Role Confusion and Conflict in Nursing" in the February, 1961 issue.

KATHLEEN F. DEJONG, Manitoba

¶*To bind your Journals, we would suggest you purchase one of our Self-Binders at a cost of $3.00. They have a hard cover and the copies are easily inserted.* Ed.

Dear Editor:

One hears a good deal lately about the need for more nurses with university preparation to fill positions in the ever-widening fields of nursing. At the same time, nurses are given very little incentive to go back and work toward better preparation.

As a start, why not have the provincial registered nurses' associations declare a re-

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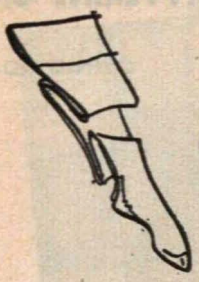

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duced registration fee for nurses who are attending university and perhaps working part-time, as part-time work disqualifies them from paying the inactive fee. The money would not make a great deficit in the associations' budgets but it would make a welcome addition to most students' purses.

EDNA MACEACHERN, British Columbia

Dear Editor:

The St. Elizabeth's School of Nursing, St. Joseph's Hospital, Sudbury, Ontario, is holding its Golden Jubilee celebrations May 27, 28, and 29. We seem to have lost some of our graduates! If any graduate has not been in touch with the School of Nursing for many years, please drop a line to the Jubilee Secretary. Please help us by publishing my letter in "Random Comments."

MARY M. CONROY, Ontario

Dear Editor:

I suppose there is some virtue in getting around rather late to reading one's professional journals. I had, of course, leafed through the February issue as soon as it came but it was only the other evening, rather late, that I read it thoroughly.

May I congratulate you on the general excellence of this issue. There is a sense in which all the *Journal* numbers are good, but it seems to me that the February issue comes to grips in a very real way with the question that is concerning us all: "What is real nursing?" From Miss Poole's editorial, on through the articles by Dr. Benne and Dr. Bennis, Miss Keeler, Mr. Ruys, Father Troy and the others there is an unmistakable attempt to cut through "gobbledegook" and rephrase in modern terms and in the light of modern demands what is the heart of nursing.

Perhaps my vanity was touched by the reference in the Benne-Bennis article to the necessity for developing a "skill hierarchy" (p. 125). This paragraph expresses, more skillfully than I was able to do, the thought I was trying to develop in my "Three Wishes" (January 1960) when I referred to "Masters of the art of nursing — practitioners *par excellence* of nursing in its widest and deepest sense — from whom the oncoming generations of nurses can learn much that is not contained in text books."

I think the February issue, all told, is one of the best planned, best integrated, and "meatiest" that you have published. You and your staff are indeed to be congratulated. More power to you!

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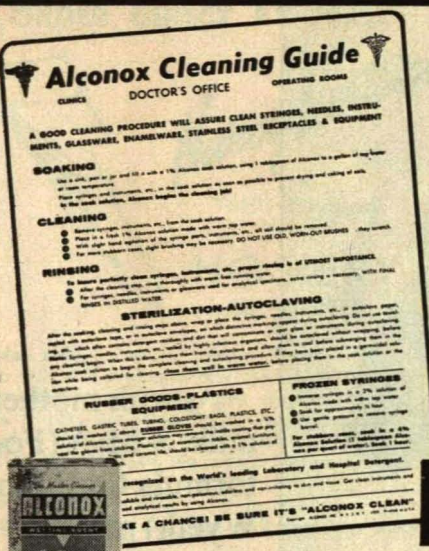

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Dear Editor:

I take this opportunity to tell you how many favorable comments I have heard regarding the series on nutrition in the November issue.

FELICE KUNTZ, Saskatchewan.

Dear Editor:

The members of the New Westminster Registered Nurses' Directory of South Burnaby, British Columbia, wish to convey their appreciation to you and your staff for the time and energy that is required to compile the many helpful and interesting articles that make up *The Canadian Nurse.*

They say a big thank you to you all.

N. WITHERS, R. SUTTON, G. TURNBULL,
British Columbia

Dear Editor:

May I take this opportunity to thank all the people who for the past six months have given so much of their time to make my study tour in Canada so interesting and rewarding.

I shall never forget the warmth of the receptions and the wonderful hospitality I received from everyone.

Some day I hope to see in Scotland many of my good friends from Canada but for the present, thank you all again most sincerely.

PHYLLIS P. ROBBIE, Royal Hospital for Sick Children, Edinburgh, Scotland.

Dear Editor:

As a nurse I have faithfully read and enjoyed the articles in *The Canadian Nurse* since training days. As an industrial nurse I have felt just a little left out of the scheme of things, so you can imagine my delight when I found the articles on Eye Care in Industry in the March issue.

I am plagued not only with foreign bodies, but have encountered the lacerations, allergies and that ever-present rust ring. The industry which employs me uses chlorine, ammonia and hydrogen sulphide in great quantities so eye irrigations and butyn sulphate have become second nature to me.

Of all the eye cases I have treated I have found the welder's flash or arc eyes the most irritating, if not the most serious.

I realize that industrial nurses are in the minority but I hope you will think of us again in some future issue.

M. KILLAM, New Brunswick

Dear Editor:

The Nurses' Alumnae of the Ross Memorial Hospital, Lindsay, Ontario, is making plans for a reunion of graduates June 17-18, 1961, to celebrate our 59th birthday.

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REFERENCES: *(1) Coon, W. W.; Wolfman, E. F., Jr.; Foote, J. A., & Hodgson, P. E.:* Am. J. Surg. **98**:*4, 1959. (2) Friedman, E. A.; Little, W. A., & Sachtleben, M. R.:* Am. J. Obst. & Gynec. **79**:*474, 1960. (3) Margulis, R. R., & Brush, B. E.:* Arch. Surg. **65**:*511, 1952. (4) Personal Communications to the Department of Clinical Investigation, Parke, Davis & Company, 1959.*

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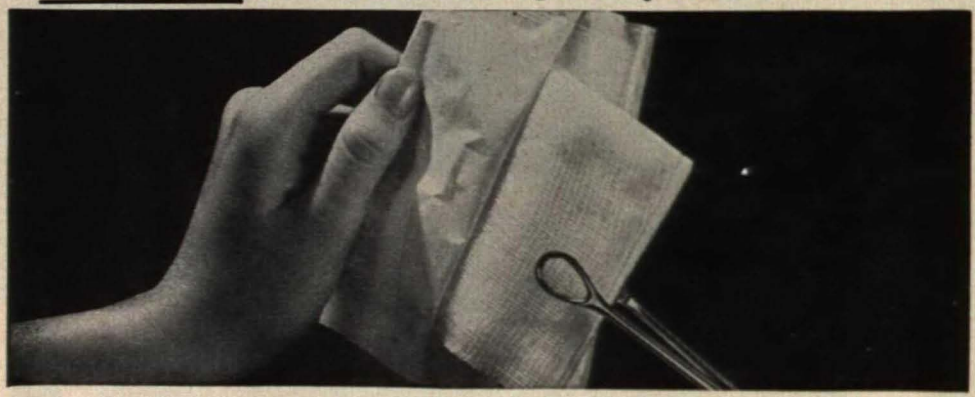

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1. Burnett, W. E.: *Program for Prevention & Eradication of Staphylococcic Infections*, J.A.M.A. 166: 1183-84 (March 8) 1958. 2. Adams, R.: *Prevention of Infections in Hospitals*, Am. J. Nurs. 58:344-48 (March 1958). 3. *Medical Authorities Recommend Ways to Control Infections*, Mod. Hospital 90: March 1958, 51-54.

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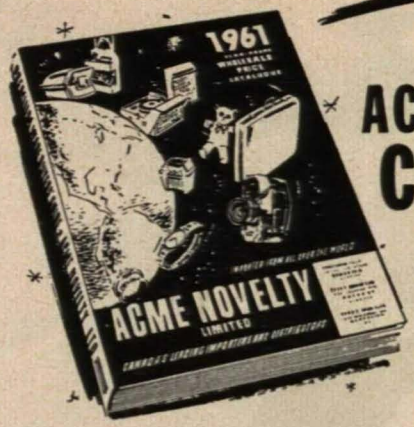

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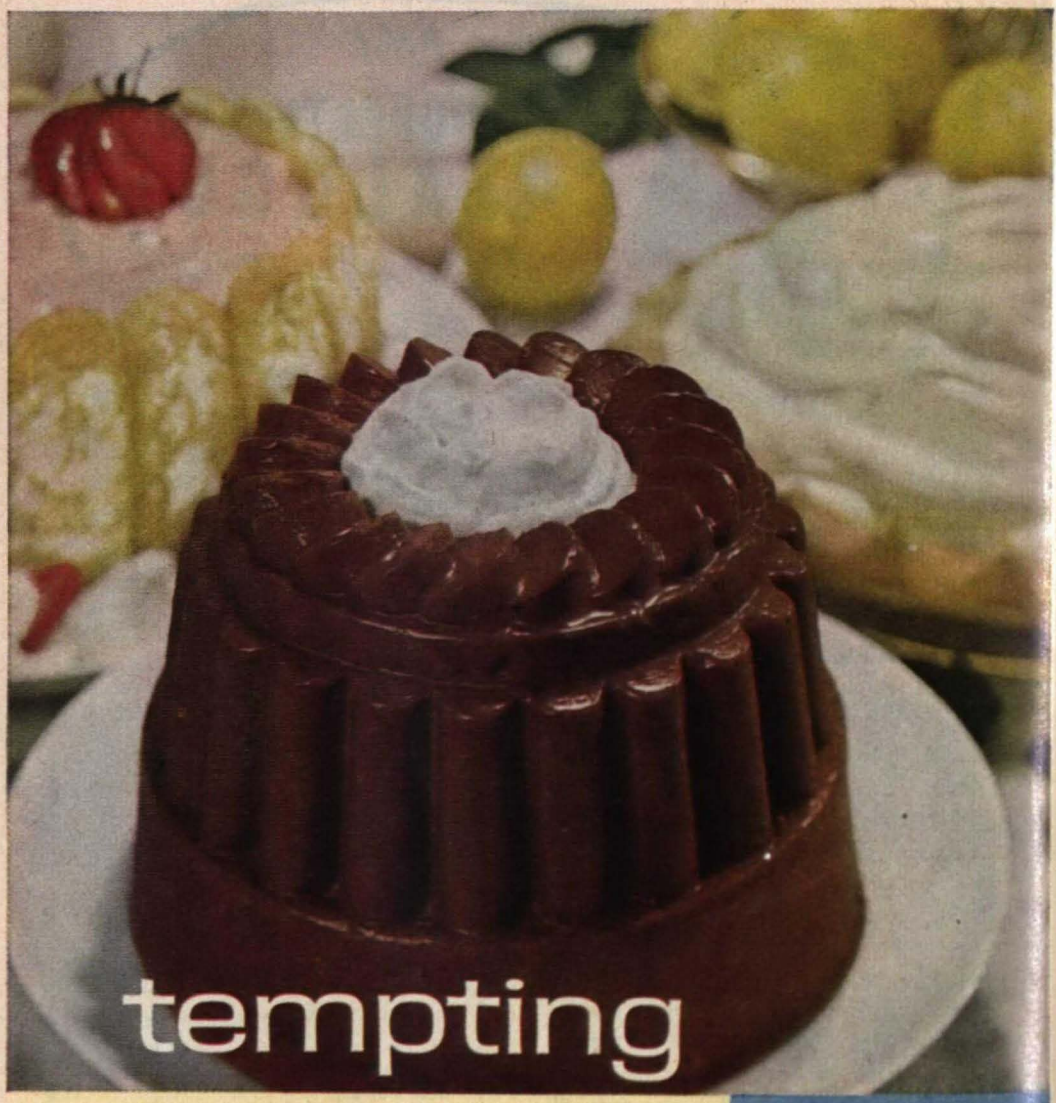

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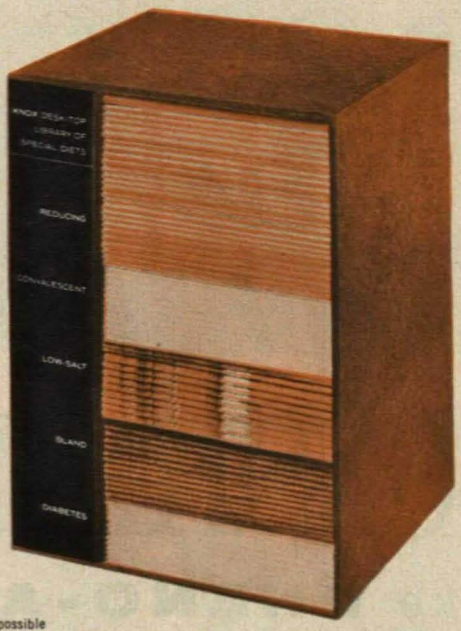

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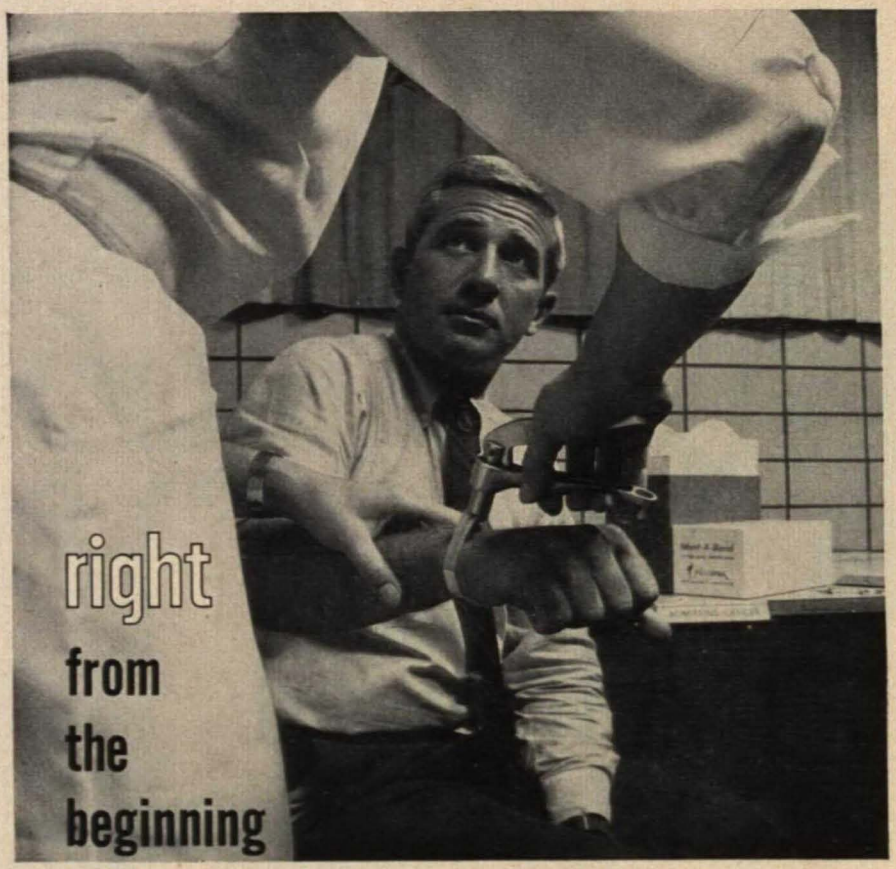

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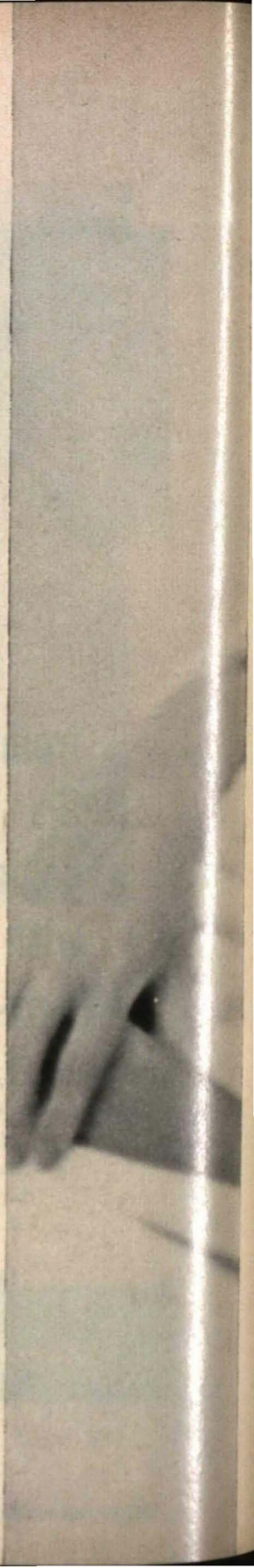

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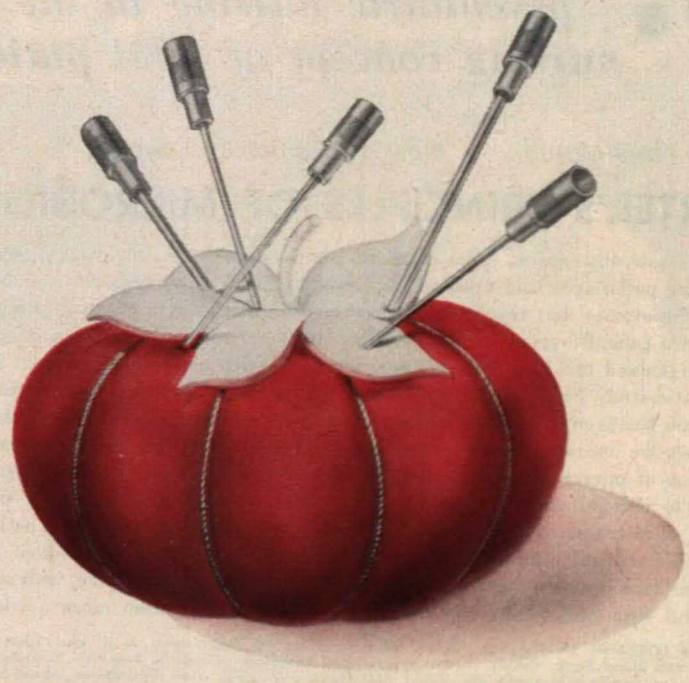

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COMMODITY -- NURSING CARE

WITH the onset of interest by the Government in health and hospital supervision and control, it is about time the nurses looked at "nursing care" with an eye parallel with that of Government control. The patients are in hospital in numbers, they are ill and they definitely require a certain amount of nursing care. Cold, hard facts, at the best of times are unkind, crude and very revealing, but usually are honest.

In any commodity that one plans to purchase and use, there are two main factors — "quality" and "quantity." "Quality" is always foremost. The "quantity" required depends on the commodity — the type of use, the length of time of use, the amount of use, and the durability in use. How can the commodity of "nursing care" be measured?

First, let us look at the quality of nursing care. The nurses of Canada have already taken an honest look at the quality of nurse that they feel would best give adequate nursing care in Canada. This has been done through the "Pilot Project for the Evaluation of Schools of Nursing in Canada" on which much has been said and written.

The impending follow-up of this project by our National Association is most gratifying. Already study and task groups are hard at work to put in action the recommendations of more immediate concern, as presented by Miss Helen K. Mussallem, in "Spot-

JUNE TAYLOR

light on Nursing Education." The quality of the commodity "nursing care" is being attacked with vision, precision, knowledge and experience by our key women in nursing education and nursing service across Canada.

A survey of the quality and the quantity of the commodity of nursing care is being made this year not only in Alberta but, I understand, in Manitoba as well. Although these surveys are government sponsored and controlled, the nurse and her professional association are well represented. These surveys are preliminary steps. The material, facts and knowledge of situations, gathered in this way, are to form a basis for future study of the needs of nursing care.

In the meantime, a study of the quantity of nursing care required may be done at local level by any individual or groups of individuals concerned, using their own methods, their own knowledge and experience in order to apply it to their situation. A director of nursing, superintendent or matron of a small hospital, is the one who is in the situation and definitely the one who knows the needs of "nursing care."

After such a local survey, conducted conscientiously and practically with the best of patient care in mind, the next step is to try to interpret these needs in nursing care to the hospital board or administration. Such interpretations and surveys can always be referred to the Provincial Nurses' Association and/or the Associated Hospital Association, for assistance and perhaps greater clarification so that the government may become more aware of that individual situation.

Should one be so fortunate in their interpretation that the hospital board and government accepts the findings of their needs in the commodity "nursing care" and they are granted the financial assistance to carry out their plan — then what? First, may I say, without a hint of sarcasm or bitterness, should such happen to you, you would indeed be most fortunate! But again, then what?

If you are in a small out-of-the-way hospital, you may be unable to obtain the nursing staff your survey recommends. What do you do now?

What happens when the required quantity of any commodity is lacking? It is either replaced by a substitute, watered-down or thinned out. What may happen, then, to the quality of the commodity "nursing care"?

Need I mention the nursing care situation in the small and even larger hospitals in out-of-the-way places? Need I add the concern of many to overcome this serious state? Some believe additional salary will entice many nurses to these areas but I do not think this is the complete answer. Much more is needed.

The young nurse going into these small hospitals must be assured of a good orientation. Her fear, as always in conscientious people, is of being in a situation for which she has not been prepared with the risk of doing harm to her patient and certainly of not being able to give the best nursing care. Improvising equipment may also be of concern to her, not to mention the fact she is very much aware of her lack of experience in the new and different situation.

The quantity of nursing care available has been a matter of concern to nurses for some time but now government has become keenly aware of it.

The number of nursing assistants is increasing at an alarming rate, yet many hospitals report that even this group is lacking in quantity. Hence, we have the ward aide, the undergraduate, the person literally trained on the job. The quantity still falls far short of requirements.

Then what? In desperation, perhaps the matron or even the hospital board may appeal to the community for help. Thus, we have the volunteer worker. These community-minded, selfless people are definitely making their usefulness felt in many hospitals and health areas. More glory to them! But what is happening to the quality of nursing care when the quantity of the commodity is found wanting? What price quality and what to do to maintain such quality? What can we do about nursing care? What should we be doing? Where should we be going? What is nursing care? What is a nurse?

D. June Taylor,
President,
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of Registered Nurses.

The New Orientation in Modern Nursing

H. LEHMANN, M.D.

There appear to be two major trends or characteristics which are evident in the new orientation in modern nursing: 1. An increased awareness of responsibilities for community health problems and 2. a steadily growing interest in and concern with the individual patient's emotional needs and reactions.

THE MODERN WORLD is full of scientific wonders. There seems to be no problem that technology cannot master today or tomorrow. There are "learning" machines and chess-playing machines. Even "thinking" machines are said to be on the drawing boards. We have conquered space with electronics and rockets. We can produce unlimited power for good or evil. We are discovering effective preventive methods for more and more of our most dangerous diseases.

And yet, in the face of all these undreamed-of achievements and successes, our new society is not becoming more confident but more bewildered. We do not live in a "brave new world," as Huxley predicted, but in an anxious new world. Humanity is not, as one might expect in view of what modern medicine has achieved, a healthy and carefree lot, but people are "sick, sick, sick."

> We live longer than our forefathers but we suffer more, from a thousand artificial anxieties and cares. They fatigued only the muscles; we exhaust the finer strength of the nerves. — BULVER

What accounts for this state of affairs? I should like to give you my explanation which is, of course, a psychiatrically-colored one. It will bring us back to the preoccupation of the nursing profession with the emotional reactions of their patients.

As science grew, our emotional life began to wither. There seems to exist a complementary relationship between science and feeling. As one becomes more elaborate, the other diminishes in power, organization and capacity. As we become technological giants, we change into emotional midgets. Of one thing I am sure — there will be no "feeling" machines, ever! There will be no *emotional* automation!

This science-emotion relationship is probably not an inevitable development but it will continue unless we find special ways of integrating our intellectual achievements with our emotional life. We will have to do this because man cannot live by thought alone. The most authentic human qualities are not intellectual in nature. If we neglect them we are out of balance, insecure, anxious. Modern man has managed to anesthetize himself very successfully to his most real, most essential needs by plunging himself into the turbulent stream of power systems, movement, automatic communication and the never-ending change and rapid pace that characterize our everyday existence.

But what happens when he gets sick?

> There was never yet philosopher that could endure the toothache patiently.
> — SHAKESPEARE

Alone, afraid, and in pain, man today is much less capable of coping with these existential contingencies than he has been in the past.

> the man "who has never known a day's illness" . . . is a moral dunce, one who has lost the greatest lesson of life; who has skipped the finest lecture in that great school of humanity, the sick chamber. —HOOD

The sick today are no longer capable of benefiting from such a school of humanity unless they have the right teacher at their bedside, understanding, wise and skilful — the modern nurse.

Perhaps some of you feel that this is greatly overstating and dramatizing the importance of our emotional needs

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Dr. H. Lehmann, clinical director of the Verdun Protestant Hospital, Montreal, gave this address at the 40th annual meeting of the Association of Nurses of the Province of Quebec in 1960.

and reactions. Let me remind you of certain evidence in favor of these opinions as indicated by cold statistics which claim that poor mental health in Canada is the nation's number one health program. From one-third to one-half of all patients who consult physicians suffer from significant emotional maladjustments. The question of whether we have more mental illness now than formerly cannot be answered. Almost certainly, a larger number of people today are incapacitated because of emotional maladjustments than ever before.

It has been demonstrated conclusively that destructive emotions such as anger, anxiety and depression will produce in many people vasodilatation, edema, hemorrhage and increased friability of tissue in the skin, nose, stomach, colon, bladder, vagina and in the subcutaneous tissue of the scalp. Pituitary, thyroid, and adrenal function may be severely altered and disorganized. If emotional disturbances persist the resulting functional changes will eventually lead to structural organic changes.[1]

The role of the emotions as regulators of our organic functioning is so important for the processes essential to the course of convalescence that I would not hesitate, if I had the misfortune to be confined in hospital with a myocardial infarction or mental breakdown and had to make the choice between a first class doctor and second class nurse or a second class doctor and first class nurse, I would unhesitatingly choose the latter — the first class nurse and the second class doctor. Medical science and technology are so advanced that probably any average physician could succeed in my medical care but the emotional problems resulting from the prolonged inactivity of illness are difficult enough to tax the skills of the most excellent nurse.

> It is in sickness that we most feel the need of that sympathy which shows how much we are dependent upon one another for our comfort and even necessities. Thus disease, opening our eyes to the realities of life, is an indirect blessing.
>
> — H. Ballon

Sickness produces regression. Our dependency needs increase, judgment is impaired, emotional tolerance diminished, impulsiveness exaggerated. This is very much a reactivation of childhood patterns. The child needs understanding and warmth, usually provided by mother. He also requires guidance and control to protect him from damaging himself through his own impulses, which is the father's role. The nurse must be able to fill both roles equally well and at the same time.

How well are today's nurses prepared for such an exacting task? What is to be done when the patient does not cooperate with the doctor's orders after a coronary? How does she deal with the anxious patient? the depressed patient? We cannot measure the warmth of a smile with a thermometer; a feeling of tension with a voltmeter; the pressure of worries with a barometer. The teaching of perception and understanding of the patient's emotional needs, conflicts and problems can only be done by teaching the nurse to recognize, understand, and *accept* her own emotional reactions. This is not material that can be memorized. This kind of information can only be learned through self-experience in a securely supervised setting.

The average patient no longer finds understanding and full acceptance in his family and often not in his doctor. He is no longer capable of dealing with his own difficulties. He depends on the nurse. She must accept his dependency and also know when to cease accepting it. She must be able to provide the right guidance for her patient in returning from his regressive state to full maturity.

The nurse today needs training and know-how. She must have secure self-possession even when dealing with the most difficult or most illustrious patient. Sickness is the great equalizer. It reduces everyone to his human essence. Acceptance, understanding, control of others is only possible if we develop these qualities first ourselves.

A strange pedagogic phenomenon has been noted in medical students. I refer to the rejection of emotional material when the student approaches studies in the specialty of psychiatry. There is some evidence to indicate that he is far more receptive to studies of personality and emotions at an earlier stage in his education. He should probably learn more human facts before entering medical school. I wonder if a

similar situation exists in nursing. Is there a possibility that nursing students might be much more receptive to consideration of emotions and personality in the early part of their preparation? On the other hand, technical skills are also necessary.

Experienced handling of emotions as well as physical and medical problems is necessary. The good nurse must be responsive to the patient's feelings as much as possible and yet know when she has to make even the simplest of decisions for him. The good nurse must have perfect control of her emotions and yet never have a "poker" face. The good nurse must be professional in her manner and yet never cold.

We can hardly expect to find such truly, extraordinary qualities combined in a single person. We must expect the nurse in the years ahead to possess such expert skills and characteristics. The nurse of the future, if she accepts her mission, may become the key person under whose influence patients rally. People suffering not only physical illness but also the ills of our civilization will seek to find again integration and balance — an integration that they have lost for a time because the balance was disturbed between the intellect and technical skills on the one hand and the human needs for emotional expression and understanding on the other hand.

Because our patients will need her very much, let me conclude with this plea to you, the teachers in nursing. See to it that the nurse of the future will be intelligent, resourceful and skilful, as good nurses have always been. In addition, see to it that she is mature and capable of human warmth and understanding.

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IN THE GOOD OLD DAYS

(*The Canadian Nurse* — MAY, 1921)

O. L. Heiser, American consul at Jerusalem, states in an official report that manna is found in the regions of Upper Mesopotamia, Kurdistan and on the Persian frontier. It falls in the autumn, in the form of dew, and lodges on the oak trees. It soon hardens and looks like grain. It is gathered by shaking the tree, under which sheets are spread to receive it. Unlike the manna that fell for the Israelites, it can be kept indefinitely. It is stored for use in the winter, or shipped to Bagdad, to be sold in the bazaars.

* * *

A Woman as Cabinet Minister: Mrs. Ralph Smith, senior member for Vancouver City in the British Columbia Legislature, has entered Premier Oliver's cabinet. She holds the office of President of the Council, without portfolio. She declined the Speakership of the Legislature before the opening of the session.

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The Canadian Nursing Unit in Roumania: Miss Dorothy Cotton, the head of the Canadian Nursing Mission to Roumania, reports that nurses are to work for two months in the Coltgea Hospital, in Bucharest, under three of the leading doctors in Roumania, who all have clever young assistants. The hospitals are good, but the nurses in the wards are in great need of training.

Queen Marie is much interested in the work, and writes that she is greatly pleased with the mission. The nurses live in the nurses' home, and the Queen sends a motor to take them to and from the hospital. Miss Cotton has been taken by the King's doctor to visit all the hospitals, fourteen in number. Plans are being made for more work. Queen Marie has personally attended two meetings and given every assistance in her power.

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A New Wireless Invention: Marconi has announced a new wireless invention by which ships may be guided during a dense fog. It is based on the principle by which electric waves may be directed in any definite direction, like flashes from a lighthouse. These waves would take the place of lights in thick weather, and prevent collision.

INVENTING THE PRESENT

RAE CHITTICK, M.A., M.P.H., LL.D.

How does advancing technology affect nursing?

The World We Live in

THE FIRST EVENING I sat down to prepare this address was the Saturday night of the Thanksgiving weekend. As I reflected, I turned the pages of a magazine to an article on electronics and learned about computers and predictors that will do all kinds of jobs better and more accurately than the human brain. The writer concluded his account with the prophecy that the Golden Age is at hand — "an amazing world awaits us just over the horizon, a world that is challenging, exciting, and promising." The writer reinforced his argument with the statement that developments that once would have required many years are now compressed into a few months and that there is an ever-increasing tempo of progress. "If one doubts this," he states, "look at the story of flying. It took forty years — from the Wright brothers to the Second World War — to push flying speeds close to 500 miles an hour. But it took less than fifteen years to go from 500 miles to the 18,000 miles an hour at which man-made satellites are circling the globe right now."[1] This constantly quickening pace of scientific and technological development means that we live in a time of rapid obsolescence. No year, no month almost, is without its startling innovations.

Our advancing technology impinges not on just a few selected areas, but on virtually every form of human endeavor. So I asked myself, "How does all this affect me, a nurse, in 1960? Does it help me to do my job better? Are people healthier and happier? Is it becoming more and more difficult to be a good nurse? Are the dissatisfactions we have experienced in nursing the result of methods that are out of date in this new world of today? Do nurses invent the present, that is, are they discovering what is happening all around them at the present time and are these discoveries meaningful to them in terms of nursing?"

Here are a few puzzling problems that confront us in this amazing new world of today, to say nothing of the one that awaits us just over the horizon.

The number of unemployed in Canada has been rising steadily and has become a serious national problem. Yet across this prosperous land of ours hundreds of beds in hospitals remain empty because there is nobody to provide nursing care. Dr. William A. Cooper writing in *The New York Times* said, "The shortage of professionally-trained registered nurses is limiting the usefulness of hospital facilities throughout the land and adding immeasurably to the cost of hospital care."[2]

The over-riding need in our technological society is for men and women equipped by education to cope with the grave challenge of this crowding progress. Yet, large numbers of children are leaving school long before they finish high school. In Ontario, which is rated as Canada's wealthiest province, the Minister of Education reported a short time ago that only 21 out of each 100 grade nine students reach grade 13, and of those only 12 manage to graduate; only seven of those who graduate go on to university and only four manage to complete the course for their degree. This means that out of every 100 grade nine students only four complete a university program, despite the fact that numerous studies have shown that 25 per cent of our students are capable of doing university work. What does this mean for nursing?

The "Golden Age" of leisure is at

This address was given by Dr. Chittick, Flora Madeline Shaw Professor of Nursing and Director, School for Graduate Nurses, McGill University, at the study day, "Nursing the Patient in 1960," during the fortieth annual meeting of the Association of Nurses of the Province of Quebec.

hand, at least according to my electronics expert, yet more and more women are entering the working force, particularly married women. Dr. Philippe Garique in his article on "The Status of Professional Women" states, "The true mother knows how to combine her responsibilities as wife, mother and career woman most effectively."[3] Marion K. Sanders writing in *Harper's* challenges our sex with the question, "What do women do in return for citizenship?" She begins her argument with this statement,

> Not long ago a freak accident killed two babies in a New York hospital. They choked to death on milk while sucking from bottles which were propped up in their cribs, because no one in the ward could spare the time to hold them.[4]

She points out that many women are employed in useless occupations, what she terms "sub-work," and suggests that women be conscripted for productive work. She defines productive work as that which is performed in or out of the home and is essential to the nurture of the family or contributes to the national well-being, enlightenment or progress.

There is a critical shortage of doctors. In 1909 there was one doctor in the United States for every 568 persons; today there is one for every 709 persons. Medical schools, both in Canada and the United States, report a diminishing number of applicants and an increasing scarcity of high-quality students. Despite the shortage, people are going to see doctors more than ever before. The average citizen today consults a doctor about twice as often as he did in 1930. According to a recent survey in the United States, the average doctor works 60 hours a week and sees more than 20 patients a day. Authorities state that at least a third of all illness today is psychosomatic in origin.

> In healing such ills which afflict the body but stem from the mind, the doctor-patient relationship is the most potent tool at our command.[5]

Unfortunately, the busy physician has little time to look beyond the organic symptoms of troubled people. Selig Greenberg in a recent article on the decline of the healing art states,

> Medicine, in truth, faces a crisis in human relations, a breakdown in communication between doctors and patients. This alienation has occurred at a tragic moment in human history. The stresses of living have intensified our need for understanding and guidance while, at the same time, the traditional sources of support, such as the family and church have weakened or broken down. We seek, in consequence, more rather than less personal attention from our physician.[5]

The amount of hospital care has increased enormously in recent times. The increase in over-all bed capacity in Canada between 1951-58 was nearly 7,000 beds. About 163,508 persons were receiving treatment and care in Canadian hospitals on a typical day in 1958. This increased bed capacity was achieved largely by adding beds to existing hospitals. In 1958 only 4.6 per cent of our hospitals were over 500 beds but they accounted for 30 per cent of the total beds. These big institutions develop special problems in providing good nursing care. The close relationship between the patient, the physician and the nurse is difficult to achieve, and we recognize that there is a breakdown of the close patient-nurse relationship.

The cost of medical care has been rising so rapidly that every family is frightened by the thought of hospital and doctors' bills. According to the United States' Department of Labor's consumer price index the cost of medical care rose during much of the 1950's at a much faster rate than the total cost of living. In 1951, the total cost of living was at 111 on the 1947-49 index, and the medical care component was just about the same level. But, by March 1960, when the total cost of living was up to 125.7, medical care had jumped to 155.[6] Since between 70 and 75 per cent of the hospital budget goes for labor and a large proportion of this outlay is for nursing service, hospital administrators, in a desperate effort to limit their deficits, take a melancholy view of any increase in nurses' salaries. At a time when skilled labor is being paid about $2.80 an hour, the average staff nurse is earning about $1.65 an hour.

There is no doubt that the salaries paid nurses is contributing to the shortage of nursing personnel. If, as Dr. Cooper states, this shortage is in-

creasing the cost of operating hospitals, the low salary scale of nurses may actually be increasing the cost of patient care. Here is a problem that nurses should consider, as well as hospital administrators. Can nurses do more to lower the cost of hospital care by finding out how time could be saved in the daily routine of the hospital and in the effective use of assisting personnel? Can more be done to improve nursing and at the same time lower costs by reassessing the whole field of nursing.

The Significance of Social Changes

We can be assured that we are going to have considerable sickness and that a large proportion of ill people will be patients in hospitals despite the wonders of our technical age. However, the pattern of our illnesses is changing. Dr. Tyhurst pointed this out at a meeting of the Canadian National Conference on Mental Health. He stated:

> Our pattern of illness has shifted from illnesses in which infection played a part to what might be called stress disorders. This means a shift away from the classic, textbook picture of a patient in the hospital bed and a change in emphasis away from the hospital-centered orientation towards a recapitulation of the whole natural history of illness which places an emphasis upon community aspects of illness, both before and after hospitalization. Hospitalization, as a factor in the treatment plan, is becoming less and less necessary for certain types of illness.[7]

Another physician, Dr. Harry Medovy of Winnipeg, has made a plea for more home care of patients:

> I wonder if we pay sufficient attention to the possibility of providing home forms of treatment for children? As soon as treatment is started in hospital, we should start thinking about carrying out treatment at home.

This, of course, means a much closer working relationship between nursing in the hospital and nursing in the home. We have only made a small beginning in our referral programs.

We should work out some method of teaching our students in situations outside the hospital. How can we give students a better idea of "The whole natural history of illness which places an emphasis upon community aspects of illnesses, both before and after hospitalization?" Have we considered the value of visits to the home after the patient is discharged? What do we do about patients who sit for long hours in the outpatient departments? Too often nursing in this unit of the hospital consists of seeing that the patient and his chart get to the right clinic at the right time.

This kind of education means that the student cannot give as much service in the hospital, but we need to take a much more comprehensive view of our health services and not keep them in such segregated units as we do now. Somehow, public health nursing and hospital nursing need to be united. I am sure public health nurses will protest that students do not know how to nurse in the home, and hospitals will say that the curriculum is too crowded to introduce anything further, and this brings me to another important point.

We cannot educate students as we have done in the past by giving them enormous doses of facts — in anatomy, physiology, pharmacology, medicine, surgery, etc. *There are just too many facts!* It would be impossible to teach even a small fraction of them. Then, too, many of these facts are out of date or have lost their relative importance before the student graduates. This means that the traditional "practical" education in nursing must shift to the "theoretical." This is difficult for instructors to accept when they are busy preparing students to give bedside care on the wards as soon as possible. Dr. Knutson of the United States Public Health Service has said that the best practical education is the most theoretical one.

> This is probably the first time in human history in which change on every front is so rapid that what one generation has learned of practical affairs in the realm of politics, industry, business and technology is of little value in the next . . . It is principles and everlasting principles, *not data, not facts, not helpful hints*, but principles, which the rising generation requires to find its way through the mazes of tomorrow.[8]

We must teach students to assess situations. They must learn to organize themselves in correspondence with

a wide variety of situations, ordering their exercise in an economical way, and building up their roles for reacting to new situations on the basis of past association. This is difficult teaching to do and requires a breadth of background and very special teaching skills.

We must learn more about the learning process. For a long time our teaching has been highly rationalistic, that is, we assume that people will act upon recognized facts. We have been assuming that all one has to do, whether teaching patients or students, is to present the facts and people will draw the expected conclusions. Human behavior is the result of emotion as well as reaction and it is in a large measure focussed through perception. People act in terms of what they perceive and of their interpretation of this information. This means that we must know much more about people's beliefs, feelings and values — students as well as patients. This knowledge is commonly derived from what we call the social sciences and this is a field of knowledge about which nurses know very little. Doctors do not know much more, with the possible exception of the psychiatrists. Hospital schools are in trouble when it comes to teaching in the social science field. Generally speaking, their nursing staff is not well enough prepared to teach in this area and they have no resource people to whom they may turn. Assistance in this field is difficult to find outside a university.

What is more, the cry goes up that the curriculum is too crowded now and why add more? It *is* too crowded, but we need to look more carefully at what we are teaching — at the detailed teaching of facts, for example. Do we need new objectives in nursing education? Do we need to re-define our goals?

Every time we talk about changes in nursing education we come up against two seemingly immovable objects. One is cost and the other is the vested interest of hospitals in nursing students. It will be a great step forward when communities can look at nursing education in a much more objective way, that is, in terms of nursing jobs to be done, the people available to do them, and the cost of preparing the people to do the jobs.

If only 21 out of every 100 grade nine students complete grade 12, we are working with individuals from the top 25 per cent of our population, at least at the top in education and ability. In other words, we are dealing with a very precious commodity. We have heard it said many times that if our way of life is to survive we must educate everyone to his greatest potential, and nursing students should be no exception. The demands of nursing service and the cost of nursing education make it very difficult for hospitals to do this. But it would seem that the cost problem might at last be met since under hospital insurance the state assumes costs, that is, hospitals are going to be run with public funds. Public funds have been used pretty generously for general education, and it would appear that the opportunity is at hand for nursing education to demand its fair share of these funds. Generally speaking, elementary and high school education is paid for by the state and also a large proportion of the costs of university education. Studies done by Canadian universities show that the students' fees pay less than one-third of the cost of their education.

I have mentioned that nursing students come from the top 25 per cent of our population. What about the other 75 per cent? Here is a large reservoir of individuals who could be prepared to do many nursing tasks, yet we have recruited only a small proportion of them into nursing. In a study made in Ontario a few years ago, it was found that not only did many hospitals not engage an adequate staff of graduate nurses to lift the weight of service from students, but frequently engaged very few auxiliary staff. They give many examples of the wide differences in staffing patterns. Here is one example quoted by the Ontario study. A hospital of 400 beds employed 69 professional nurses and 54 auxiliary nurses for bedside nursing. Miss Mussallem found in her study that only 68 per cent of the hospitals in the Pilot Project met the criteria for availability of non-professional personnel for clerical duties and for helping with patient care. One hospital had only one nurse on general staff duty.

Here is an important problem for

our nursing service people to study. What kinds of people do we need to give good nursing care? How should we prepare them? How can we make better use of assisting personnel so that our professional nurses have more time available to give good nursing care? I should like to suggest that one of the answers is automation. For an interpretation of automation I shall refer you to Peter Drucker, the great American authority on management. His interpretation of automation is not of the push-button variety; in fact he says automation is not "technical" in character.

> Like every technology it is primarily a system of concepts, and its technical aspects are results rather than causes... It focuses on the process, which it sees as an integrated and harmonious whole. Its aim is to arrive at the best process — the process that will produce the greatest variety of goods with the greatest stability, at the lowest cost and with the least effort. It is dependent on men properly trained in new concepts and skills.[9]

We need to see nursing in our community as an integrated and harmonious whole. We need to study the process and the best kind of preparation for the various groups of workers who will be working to achieve it.

In concluding, I should like to leave three ideas about nurses and nursing that have been expressed by important and thoughtful people. First, the editorial in the October, 1960 *Nursing Outlook* entitled "Talking Point," which was copied from the July *Nursing Times*, the official organ of the Royal College of Nursing. Here are the two concluding paragraphs:

> Whatever the advances of medical science, however hard we work in the field of public health, however far we go with preventive medicine — eventually we shall all, and that includes you and me, die. We may die from disease (which we are unlikely to abolish completely), from accidents or from old age. Probably we shall die in our beds and at our bedside we shall need a nurse. Then it is that the skill and deftness in the use of her hands will be needed by each one of us.
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> Sometimes I wonder if we are slipping back into the pre-Nightingale era, but with a degree under our arm instead of a bottle of gin. Both might be consoling, but neither will be of much comfort to the dying or suffering patient.

I mention this editorial because there is a tendency for people to believe that when nurses from university schools speak about the improvement of nursing education, they mean that all nurses should be educated in universities. I am sure that you will agree that this is neither practicable nor desirable.

The next thought about nursing was expressed by Dr. Cyril James, the Principal of McGill University to our first-year nursing students. He said that in his opinion we need a different kind of nurse for the society which is emerging — one less concerned with pathology or organic diseases and more interested in opinions and personalities than the physical needs of the body. He thought the nurse should be concerned with companionship, leadership and inspiration, equipped to provide a stimulating environment for the kinds of patients who are in our institutions, particularly those with mental and chronic illnesses.

The third opinion about nursing was expressed by Gertrude Hall in her last address to the public. She stated that nursing should "Create a pool of contentment about the patient."

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NURSING THE PATIENT

ELIZABETH LOGAN, B.SC., M.N.

What is good nursing today? Though we do not find it easy to say what it is, generally speaking we recognize good nursing when we see it.

IS NURSING different in 1961? To this question we immediately answer emphatically "yes." We are very much aware that the modern nurse is engaged in many kinds of activities that have increased in number and complexity. In our efforts to examine and define nursing, much energy seems to have been directed towards counting and timing the *activities* of nurses. Though the studies done have served to show us some of the boundaries of nursing they have an elusory quality in that they do not make the *substance* of nursing clear.

We find the nurse engaged in planning, managing, ordering, teaching, evaluating, etc. All of these duties are obviously important in the restoration and promotion of health which is our primary concern. Some of these activities take the nurse away from the patient. Others place the nurse in close contact with him. It is the latter group of duties that have ultimate significance for nursing. It is in relation to them that we must decide about *good* nursing. They seem to be the ones involved when we hear the plea to let the nurse go back to the bedside.

Of all those who are engaged in the promotion of health it is the nurse who spends the most time with the patient. This fact alone would seem to place a distinct responsibility upon her. Because of her closer contact with him certain needs of the patient become her concern. What are these special needs?

Let us look briefly at our present ideas of health and what they imply. Formerly we thought of our task as caring for the sick person so that he would be made well and would be able to leave the hospital, to return to what we were not sure. We thought of prevention of illness as something to be taken care of by the community — a remote place that we did not need to bother about. It lured away some members of the nursing profession into a highly specialized activity known as "public health nursing." Now we see that the knowledge and skills of the public health nurse are necessary to all nurses. Health is no longer simply the opposite of illness but an index, at any given time, of a person's adjustment to his life situation. Health is a relative quantity — poor, better, good, etc. With this broader view we we can see that the patient is not only the person in the hospital or the one who is sick in bed at home.

If health breaks down and the person must go to the hospital perhaps we can see, in finer relief, what nursing can be. When an individual recognizes that he can no longer function at what he considers to be his usual level he becomes disturbed. He seeks help, professional help. It is true that he may have tried to cure himself first or may have asked the local druggist to suggest a remedy. He is distressed, uncertain about the future. In the hospital, he is removed from familiar surroundings and separated from people whose relationships have a special meaning for him. Because he is sick there are many things that he cannot do for himself. He becomes dependent, which may cause him further distress. Waiting to hear the outcome of the doctor's investigation creates anxiety. Treatment is frequently painful and upsetting. We see the possibilities for mounting degrees of tension and anxiety which eventually may become unbearable.

In what particular ways can the nurse help the patient? First of all, she must help him to meet what we call his basic needs — food, personal hygiene, rest and comfort. We do not argue this point but, in fact, take it so much for granted that it is reduced to routines. Occasionally we hear it

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Miss Logan, Professor of Nursing, McGill University, Montreal, gave this address at a study day during the 40th annual meeting of the ANPQ.

said, when fulfilling basic needs form a major part of the patient's care, that "there is no nursing care for this patient." Miss Dorothy Johnson in her excellent article "A Science of Nursing," *Nursing Outlook*, April 1960, points out that it is in this area of nursing that most of the problems arise. She suggests, and rightly I think, that the ways in which they are solved will determine the quality of nursing. What is involved in persuading a patient to eat, in addition to appearing at intervals with a tray of attractively arranged, nutritionally balanced foods? What does this food represent to the patient excepting a task that, at the moment, he feels unable to undertake? What implications does this situation have for nursing action?

We speak of providing a "therapeutic environment" for the patient. This means one in which the patient can marshal his resources to achieve improved health; where he is not expending his energy in worrying about how and when things will be done or whether he will be lost in the busy, efficient environment where sometimes everyone seems to be concerned about everything excepting him. The patient brings many of his anxieties with him. The nurse has the opportunity to establish a relationship that will engender confidence and allow for expression of his worries and fears. We frequently deplore the fact that time does not allow for this.

As medical science makes more and more treatments available to the patient, the nurse accumulates more techniques that require an increasing amount of her time. We sometimes think of these activities as preventing us from providing the necessary supportive environment. Could we not perhaps look upon them as one way to achieve the desirable relationship? It becomes more than just a matter of getting things done and ticked off in the appropriate place. The *way* in which treatments are carried out assumes greater significance. By her manner, the nurse can transmit a desire to help, a sense of the individual's worth, a feeling of sympathy. The patient develops a feeling of confidence and enjoys a release of tensions. As she ministers to him the nurse has many opportunities to "listen" with her eyes as well as her ears. A patient who cannot express himself in words communicates in many other ways.

The relationship between the nurse and her patient usually does not just happen. It starts with the nurse and her desire to understand and to help her patient. Her effort to understand, unfortunately, may lead to unnecessary and distressing probing. If this is to be avoided the nurse requires an understanding of people in general, including herself. Though each person comes from a particular background that has contributed to the formation of his attitudes and responses, in the last analysis he has his own way of viewing things. A knowledge of her patient's background, his family and social setting have meaning only if the nurse can interpret them as they relate to the situation at hand. Ability to do so leads to an understanding and acceptance of the patient's problem and the way he feels about it, and stimulates appropriate nursing action.

Health teaching need not be looked upon as merely transferring information or "telling" people things. On the basis of the nurse-patient relationship we see health teaching rising out of a feeling of confidence on the part of the patient along with a real understanding of the patient's needs, on the part of the nurse.

Nursing should offer comfort, support, nurture and help so that an individual may move from a state of dependency to one of independency, so that he can more nearly achieve his potential for good health. The patient's progress along the *continuum* of health may be great or small. He may go from a complete breakdown in health back to his place in the community. He may start with only an imminent breakdown. To help the patient and his family to mobilize his resources, or to assist the patient in his journey to good health the nurse has many healing skills, her nursing techniques. Fundamental to all of this is the nurse-patient relationship based upon an interest in and understanding of the patient, through which the nurse can work with him to help him achieve realistic health goals.

Perhaps the foregoing has called up in your imagination only a picture of the patient in the hospital bed. Perhaps

the complexities of the hospital slant our vision so that we find it difficult to see nursing as I have tried to describe it. But what of the nurse in the home to which a new mother has just returned with her baby? Here, the nurse is truly a comforting, supporting helper. Through her ability to establish a good relationship, the nurse can apply her knowledge and skills in such a way as to help this family in making a happy adjustment. What of the child in school? He has embarked upon a developmental task, that of finding his place outside the home in a new and different environment with new and increased responsibilities. The nurse and the teacher help the child over his difficulties. Sometimes it is through the nurse's relationship that this can best be achieved. Nursing, wherever it is found, is comforting, supportive, helpful, and is based upon the relationship of the nurse to her patient.

If this is good nursing now, is it different from nursing in the past? I believe the answer is both "no" and "yes." No, because as far back as nursing has been mentioned in literature it has been spoken of as comforting and supportive. It has been thought of as a female role undertaken by women of devotion. Yes, because our world has become more complex. Our ideas of health have broadened and the ways of coping with health problems have become more varied. In order to carry out her function the nurse must become involved in management, planning, teaching, etc., that take her away from the patient and obscure her view of nursing. At the same time the nurse with newer knowledge and skills can help her patients to achieve realistic health goals more effectively.

We must continue to deepen our understanding of our patients within the context of their families and communities. We must stand firm in the conviction as to what our role is in the health team. Our perceptiveness of people's needs should be sharpened. This is necessary to all of the health professions. What is truly nursing, is our responsibility. When we envision nursing, as I have tried to described it here, the first question that comes to mind is "how will we find the time?" Perhaps we need to consider a different use of our time. Perhaps we are doing things that patients really do not need.

Coming!

in June 1961

Guest Editor — Miss Helen K. Mussallem
Director of Special Studies
Canadian Nurses' Association

Sommer — Who Should Teach Specialized Courses?

Sr. Forest — The Instructor in Nursing

Sr. Laurette — The Clinical Field

Gemeroy — Teaching in the Clinical Field

Long — Preparing the Third Year Student for Responsibility

Olivier — The Public Health Nurse

Plus additional material

A frustrated motorist had been trying to pass a truck for many miles. Every time he tried to go around, the truck driver increased his speed or swerved toward the middle of the road. Finally, at a stop sign, the motorist pulled alongside the truck drivers' window. "Well?" growled the truck driver, glaring viciously. "Nothing important," was the motorist's reply, "I know what you are — I merely wanted to see what one looked like."

* * *

Q. — How did the name of Grand'Mere, Que., come into existence?

A. — French for grandmother. The name is derived from a rock in which the Indians saw the likeness of an elderly woman's profile.

THE HEAD NURSE

SISTER GERMAINE MICHAUD, B.SC.ED.N.

What do we expect of the head nurse and how should she be prepared to meet her responsibilities?

GOOD PATIENT CARE is dependent upon the coordination of ward activities by a responsible individual who is capable of unifying efforts and creating an atmosphere conducive to good care. The multiplicity of duties involved in nursing, medical and paramedical care; the problems arising from educational programs at different levels, especially in a teaching hospital; personal relationships with patients, their relatives, doctors, nurses, all of these add to the complexity of the head nurse role.

Before defining the head nurse role, let us examine present trends in nursing service organization:

1. *The tendency towards centralization.* In this situation the head nurses are responsible to the supervisors who, in turn, are responsible to nursing service administration. Customarily the supervisors, as their main functions, undertake interpretation of administrative policies; oversee the administration and supervision of two or three patient units each or perhaps of an entire unit in medicine, surgery etc.

2. *The tendency towards decentralization.* Every head nurse, under this setup, is directly responsible to nursing service administration. Her responsibility is greater, her role more complex. The head nurse must be able to depend upon assistance with her work.

Responsibilities of the Head Nurse

1. Organization and administration of her ward.

2. Patient care: a. Interpretation of general policies affecting all personnel.
b. Evaluation of patient care.
c. Evaluation of personnel efficiency.
d. Study of administrative methods to ensure smooth and pleasant functioning of her ward.
e. Evaluation of educational resources within the ward.
f. Evaluation of communications system.

3. Supervision and research.

4. Education of the staff at all levels.

5. Interrelationships and communication
a. with doctors,
b. with other hospital services,
c. with the school of nursing,
d. with patients and their relatives.

This is not intended to be a complete discourse on the functions of the head nurse. Only a few special points will be noted. The head nurse's responsibilities are multiple and complex. She must have capable assistants to share the load and work with her. The inservice educational program and supervision of bedside care could be entrusted to one person. The teaching program for the student nurses would be the responsibility of the clinical instructor. Relationships with doctors and other hospital services could be the province of a third person. This would leave the head nurse free to concentrate on organization, administration, general supervision, research and general interpersonal relationships.

According to Webster's dictionary to organize means:

> to give structure to, to arrange or constitute in interdependent parts, each having a special function or relation with respect to the whole.

Another definition looks upon organization as the regulation of all factors to achieve cooperation and final attainment of an aim.

The head nurse must organize her staff and the physical facilities of her ward in such a way as to ensure achievement of these objectives: better patient care given by a happier staff of sufficient number and quality, working reasonable hours under good physical conditions of work.

Administration means the act of managing, governing, ruling, orienting

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Sister Michaud, director of operating rooms at Hotel Dieu Hospital, Montreal, gave this address at the study day of the ANPQ in 1960.

and directing. The head nurse must administer her ward according to standards set by nursing service and hospital administration. Each member of the ward personnel must understand her specific role. With thorough orientation and good direction, the staff is stimulated to work together for the general welfare of all. The head nurse must be in a position to cultivate this atmosphere which makes the difference between doing well and doing better.

To supervise literally means "seeing above." For this reason many believe that it only signifies control and inspection. It has a much broader meaning than this and, in the long run, it can mean what we want it to mean. What does supervision mean to the head nurse? Research? Evaluation? Assistance?

It may mean evaluation of the care given to the patients, evaluation of the attitudes and performance of the staff. The head nurse as a good supervisor cooperates in developing the individual abilities of her staff to the full. She must also see to it that the policies and directives of the hospital are thoroughly understood. She must constantly study methods of work improvement. Evaluation of ward resources for educational purposes and the use of these for her staff at their separate levels are also part of her function.

In order to fulfil her role, the head nurse must have time to think, to listen, to meet with her staff since her art lies in providing nursing care through the medium of others. It is suggested that she should set aside definite periods of time for staff interviews. At this time, any member could discuss her difficulties with opportunity provided for enriching relationships.

Finally the head nurse as the key person in the unit is responsible for intradepartmental and interdepartmental relationships and communications. These must reflect the spirit of teamwork, of cooperation and coordination between doctors, administrative personnel, nurses, dietitians, social workers, etc. Such relationships must also incorporate a general spirit of goodwill towards patients, their relatives, and the ward personnel.

To organize, to administer, to supervise, to educate, to care for, to communicate — this is the role of the head nurse. Under what conditions can she fulfil it?

Requirements for Head Nurse

1. *Aptitude:* A sense of authority and of responsibility; the act of passing on knowledge to others; the capacity to analyze, to coordinate, to stimulate, to understand, to improve upon existing conditions; above all, love for patients, work and life.
2. Broad *experience.*
3. *Advanced preparation* in organization and administration, in supervision, in education, in nursing and, if possible in philosophy.

The head nurse is one cog within the total picture. She cannot function in isolation but must unite with the other members of the total team in order to achieve better care for patients.

Nibbling as the mood strikes you may be healthier for the heart than eating regular meals. It has proved so for chickens, according to a report in the January-February issue of *Circulation Research.*

Nibblers were allowed free access to food 24 hours a day. Meal eaters were given the same foods but only twice or three times daily. Meal eaters exhibited double the serum cholesterol levels and seven times the severity of coronary atherosclerosis as nibblers.

The implications of this study are consistent with the findings of other scientists who have reported that "when humans were transferred from a meal eating to a formula diet fed five times a day, regardless of the fat in the diet and the formula, the increased number of feedings was accompanied by a decrease in serum lipids."

— *American Heart Association*

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Council of the Saskatchewan Registered Nurses' Association has announced that effective January, 1963, the minimum entrance requirement to schools of nursing in the province will be Grade XII.

Health Newsletter, Sask. Dept. of Public Health.

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To be ignorant of one's ignorance is the malady of the ignorant. — A. B. ALCOTT

NURSING PROFILES

Canadian nurses have had an interest in Teachers College, Columbia University that dates back to the time that a distinguished nurse and former Canadian went there to direct its activities. The name of Mary Adelaide Nutting is inextricably associated with Teachers College. Many Canadian nurses have followed advanced study there and continue to do so. A great number of American educators in nursing have become familiar names to us. Such is the case with Dr. **Eleanor C. Lambertsen** who has been appointed head of the department of nursing education at Teachers College. She will begin her duties at the start of the 1961 fall term.

ELEANOR LAMBERTSEN

To many Canadians, Dr. Lambertsen is known as the author of *Education for Leadership in Nursing Practice.* Others may associate her with the concept of team nursing, a method in nursing care now widely used throughout Canada and the United States. Former Canadian students may remember her as an assistant professor in nursing education at Teachers College. Her experience has been varied and very extensive. She is presently the director of the Division of Nursing and assistant secretary of the Council on Professional Practice of the American Hospital Association.

Professor **R. Louise McManus** is retiring as head of the department of nursing education, Teachers College in June of this

LOUISE MCMANUS

year, after 14 years in that post. Active in nursing for nearly 45 years, Mrs. McManus is an outstanding American educator in nursing. In January, 1961 she was one of nine nurses honored at ceremonies marking the 150th anniversary of the founding of Boston's Massachusetts General Hospital. She was awarded a citation and medal for outstanding work and for her contribution to improved patient care.

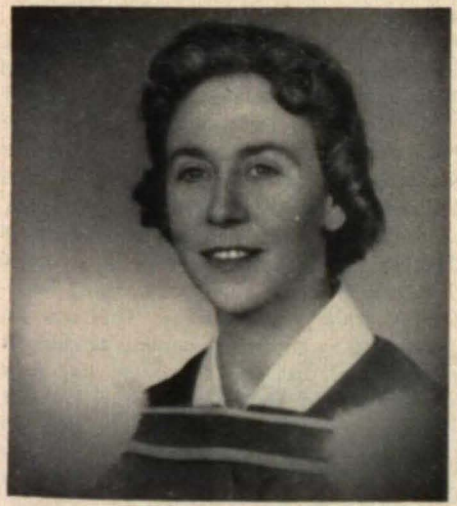
Among the many developments in nursing with which her name has been connected, we can cite her design for a national testing service for educational programs; initial experiments that led eventually to team nursing; two-year academic programs in nursing within junior and community colleges and, most recently, organization of the National Fund for Graduate Nursing Education which aims to provide aid to schools offering graduate studies in nursing and nursing education.

Under her capable direction, Teachers College has expanded its services in various areas. As an author, she has contributed to the professional growth of hundreds of nurses. Many will recall Mrs. McManus as co-author of *The Hospital Head Nurse.* On an international level, she served as chairman of the Nursing Council of the Florence Nightingale International Foundation.

(Rice, Montreal)
ELSBETH GEIGER

The Hospital for Sick Children, Toronto has announced the appointment of its new director of nursing, **Elsbeth Geiger.** A graduate of Royal Victoria Hospital, Montreal, McGill University School for Graduate Nurses, and Teachers College, Columbia University from which she holds a master's degree in hospital nursing administration, Miss Geiger has had extensive experience. She is a former director of nursing, Queen Elizabeth Hospital of Montreal and of the Royal Alexandra Hospital, Edmonton.

She is a past officer of the Association of Nurses of the Province of Quebec and of Zonta International.



NORAH MUSTARD

An English graduate who came to Canada for postgraduate study at the School for Graduate Nurses, McGill University has been appointed as matron of Manchester Royal Eye Hospital. **Norah Mustard** came to Canada in 1957 after being awarded the British Commonwealth Nurses' War Memorial Scholarship. She obtained her Bachelor of Nursing in 1959 majoring in advanced nursing education and hospital administration.

Graduation from McGill University was followed by an appointment for one year as medical and surgical clinical instructor on the staff of the Atkinson School of Nursing, Toronto Western Hospital. As part of her new duties, Miss Mustard will be responsible for affiliating student nurses; nurses enrolled in the course leading to an ophthalmic nursing diploma; assistant nurses registered in the hospital training school.

Jean Isabel Masten, a popular and well-known Ontario nurse, is retiring in June from her position as director of nurses, Hospital for Sick Children, Toronto.

Miss Masten, born in Toronto and educated in Canada and England, is a specialist in physiotherapy as well as a nurse. She graduated from HSC in 1930, took a year's basic course in administration and teaching at Bedford College, University of London and in 1939 was appointed director of nursing of her home hospital. In the intervening years she has watched the institution grow physically and expand its services. With her capable assistance, the hospital moved from its old, crowded quarters to its present location, a move that in Miss Masten's words entailed "a complete reassessment of the whole nursing set-up."

One can not break an association of so many years' standing without regret. Her associates will share in this regret from a personal sense of loss. However, the future will not be idle. Miss Masten has her own cosy home, a garden in which she loves to work and a variety of hobbies — all designed to keep her happily occupied.

In 1949, **Florence Harriet Walker** undertook the exacting duties of secretary-treasurer, now executive secretary, of the Registered Nurses' Association of Ontario. Her association with the RNAO really extends back to 1945 when she was employed as associate secretary and editor of the *RNAO Bulletin.*

The years that intervened between her graduation from Hamilton General Hospital, Ont. and her appointment to the provincial staff were filled with study and work of an administrative nature. She graduated from

(Ballard & Jarrett, Toronto)

FLORENCE WALKER

the University of British Columbia with a bachelor of arts degree and her degree in nursing. Three years as instructor at the Hamilton General Hospital were succeeded by an administrative position in the Vancouver General Hospital. Then in 1938 she accepted an appointment as supervisor of the Infants' Hospital, Vancouver — a division of V.G.H. In 1943 she joined National Office staff as assistant secretary.

Ontario is home to the largest percentage of Canada's nurse population. Over the years the work of the RNAO has expanded, grown more complex and more demanding. Miss Walker has seen and participated in much of this expansion. One major highlight was the construction of the RNAO building. She is undoubtedly one of the most experienced and knowledgeable persons in professional affairs that we have in Canada. Her work on behalf of the registered nurses of Ontario has gained her much experience in matters related to legislation, finance, personnel relations and similar matters related to the profession. Her intense interest, her enthusiasm, her unflagging energy have carried her through many difficult situations. Her counsel will be missed, her place will be hard to fill; her reward is the appreciation of thousands of nurses for a job well-done. She will reside in Glencoe, Ontario.

A Tribute to Agnes J. Macleod

(Excerpts from an address by Miss Jessie Morrison, Matron, Veterans' Home, Edmonton).

IT WAS DURING THE SUMMER of 1929 that I first met Miss Macleod. Our lives touched briefly then, as they were to do at frequent intervals over the years. She was, at that time, on the staff of the Travelling Clinic — a pioneer venture and the first of its kind anywhere in the world. Living under canvas, moving from one isolated rural area to another by truck and car, it was a training ground for the strenuous days that were to come in the battle areas of the Mediterranean and Europe.

Coming from a family of strong military traditions, it was not surprising that the first months of the war 1939-45 saw Miss Macleod in the uniform of His Majesty's Forces. She saw service as Matron of No. 4 Casualty Clearing Station which was mobilized in the Edmonton district; No. 1 Neurological Unit, Basingstoke, England, and later of No. 5 Canadian General Hospital. In the summer of 1944 she was called to England to become matron of a Canadian General Hospital that was to see service in North-West Europe. While with this unit in Normandy, Miss Macleod was recalled. This time she returned to Italy as Matron-in-Chief of the Royal Canadian Army Corps Nursing Services in the Mediterranean theatre.

Her military service is a matter of record, and the honors and medals she was awarded form an important part of this memorial.

While the war in Europe and the Far East was drawing to a close in the spring and early autumn of 1945, the existing facilities of the newly-created Department of Veterans' Affairs in Canada were greatly overtaxed because of the large numbers of wounded returning home. A rapidly expanding building program was underway. This was accompanied by expanding nursing services. It was decided that a new position should be created, that of Matron-in-Chief or Director of Nursing Services, as it later became. On August 15, 1945, Miss Macleod became the first to hold this office in the Department of Veterans' Affairs.

She undertook a herculean task. During the years that followed, the nursing strength rose from around 500 to over 1500 at the time of her death. Be it said to her honor,

(Portrait by Paul Pedersen, Ottawa)

This portrait was presented as a memorial to their late Director of Nursing Services by the nurses of the Department of Veterans' Affairs across Canada. It hangs in the Agnes Macleod Memorial Library, University of Alberta Hospital, where it is being viewed by ANNA NORSTEN, MARJORIE RUSSELL and JESSIE MORRISON.

that her will and unflagging purpose to provide the veteran patients with the best possible nursing care, permeated the nursing service of every veterans' hospital across Canada.

Always of the belief that the nurse who carried out her professional obligations was the nurse who was most capable of giving her best to her work, Miss Macleod followed precept with example. For many years she served on the executive of the Canadian Nurses' Association in various capacities and offices. Perhaps her greatest contribution in this area was her work with the committee that ultimately set up the Demonstration School of Nursing, Windsor, Ontario, in 1948 in conjunction with the Canadian Red Cross.

Always impatient with the "status quo," she encouraged the nurses of her service to grow professionally, to broaden their horizons by taking postgraduate study, and to read widely. She guarded jealously against any encroachments that might impair the prestige of nursing. Perhaps we are too close, at this moment, to catch the perspective that reveals the true dimensions of such a personality. As one must stand back afar to see the mountains in their true grandeur, so I believe that time will accord to Agnes Jean Macleod a place among that select company, Canada's outstanding leaders in nursing.

"Nine to Twelve" is the title of the latest addition to Metropolitan Life Insurance Company's series of child-care booklets. It is designed to help parents understand their pre-adolescent children and includes such subjects as discipline, groups and clubs, health problems, school problems, comic books, television, allowances and the teasing of younger children.

Booklets published previously are "Preparing for Parenthood," "Your Baby," "Understanding your Young Child," "Six to Eight," and "Understanding your Teen Ager." Copies may be obtained free of charge from your Metropolitan district office, or by writing to: Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10, N.Y.

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Last year the Canadian Junior Red Cross exceeded its objective of $150,000 to help refugee children.

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Reorganization in National Office

The time had come when the efficiency of your National Office should be evaluated, especially as it relates to office management and the assignment of work. Through the Deputy Minister of National Health the services of Miss OLIVE WATERS, departmental secretary, Department of National Health and Welfare, were obtained. Miss Waters' study included a review of our files and our method of filing, a time and activity analysis of our clerical staff positions and a review of the overall activities of National Office.

The staff had also studied their respective positions and titles with a view to promoting a more efficient and effective program. The Executive Committee meeting in Ottawa in February, 1961 approved the following new plan.

> The senior executive in national office is to be known henceforth as the Executive Director. Associated with her in the "management" of the Association activities there will be two senior persons — an Associate Executive Director and a Business Manager.
>
> The Associate Executive Director's preparation, experience and abilities should be such that in the absence of the Executive Director she could act in all aspects of the Association's administration. She will be directly responsible for the work of the professional secretaries of National Office.
>
> The Business Manager, under the Executive Director, will be responsible for the administration of business activities and transactions of financial affairs of the Association.

These two appointments will relieve the Executive Director of many of the administrative functions. She will, therefore, be more free to represent the CNA at meetings of our own nurses as well as to keep a watching brief on the activities of other groups as they relate to nursing. When matters which influence nursing are under discussion in the House of Commons, the Executive Director can be there gaining first-hand knowledge for the benefit of the Association. Similarly, she can attend public hearings before Royal Commissions when such have any bearing on nursing.

Many of the non-nursing duties previously carried by the assistant general secretary and assistant secretary-treasurer will be taken care of, enabling these nurses to assume broader nursing functions.

Program of Special Studies

Members of the staff welcomed HELEN K. MUSSALLEM on her return to National Office the end of January. The recommendations contained in her report of the Pilot Project to the general meeting in Halifax, and the subsequent recommendations of the Executive Committee meeting in Charlottetown, set in action three projects, namely:

1. A study of the whole system of nursing education.
2. A school improvement program.
3. A study of the nursing service areas in which students are receiving their clinical experience.

Miss Mussallem has been appointed Director of Special Studies to initiate, coordinate and direct the three projects. She will devote her attention primarily to the first project.

F. LILLIAN CAMPION has been transferred to the Special Studies Program and will initiate the study of the *quality of nursing service*. A small

committee with representation from the nursing service and nursing education committees is to be named to work with Miss Campion on this project.

GLENNA ROWSELL was appointed to the staff as of March 1, 1961 and will be responsible for the *school improvement program*. Miss Rowsell is warmly welcomed to National Office.

The CNA House Committee

Miss JEAN S. WILSON, the first Executive Secretary of the Canadian Nurses' Association from 1923 to 1943 recently made a donation of $425 for the purchase of a sterling silver tea service for National Office as a memorial to her sister. The presentation of the sterling silver tea service was made during the Executive Committee meeting by MILDRED I. WALKER, chairman of the CNA House Committee, on behalf of Miss Wilson to HELEN M. CARPENTER, CNA president. *(See accompanying picture).*

The CNA House Committee is studying the city of Ottawa and endeavoring to gain information regarding suitable sites for the building of our own national headquarters.

The Association expresses its appreciation of the efforts of the National Office Auxiliary, which is making regular contributions to the CNA House Fund.

ICN Visitors

Appreciation of the organizational work of Canadian nurses through WHO in Malaya was expressed recently by Miss ONG POH TEEN, tutor at the Penang School of Nursing in Malaya, while on a brief study tour in Canada. Miss Ong stated there has been rapid progress in the development of the school program and in the preparation of Malayan nurses for undertaking roles of leadership in the program.

National Office also welcomed Miss MARY EVANS, deputy director, Melbourne District Nursing Service who has spent three weeks in Canada observing public health practice and rehabilitation services. Our staff enjoyed

(Studio C. Marcil)

Mildred Walker *presenting the sterling silver tea service to* Helen Carpenter.

discussing with Miss Evans not only the highlights of recent developments in nursing in Canada but also trends and developments which she had observed in England and the Scandinavian countries. These visits were not limited to an exchange of ideas and programs. Miss Ong and Miss Evans both contributed to the CNA House Fund. This gesture of helping hands across the seas is much appreciated.

ANA Section Regional Conference

LAURIE MCCOLL, Nursing Service Secretary and FRANCES HOWARD, Nursing Education Secretary, report a happy and profitable time spent at the conference in St Louis, Missouri. The featured attraction was Better Patient Care with some outstanding nurses as speakers.

MISS FRANCES REITER, dean of the new Graduate School of Nursing at New York Medical College and Flower and Fifth Avenue Hospitals in New York gave the opening address, "The Improvement of Nursing Practice." Miss Reiter is directing a reorganization of nursing services in Flower and Fifth Avenue Hospitals for improving nursing care under which nurses are relieved of non-nursing duties in order to give direct care to the patient.

The second day was devoted to discussion of improvement of general nursing care. Five approaches were used in simultaneous sessions, namely:

> administration, the practitioner, the significance of ritualism in nursing for patient-centred care, responsibility of the professional nurse to allied personnel in nursing, and areas of learning needed to broaden the nurse's recognition of the patient as a member of a family and a community.

The continuing development of the nurse practitioner was featured on the third day. The responsibility of the professional association was noted in encouraging nurses to improve their nursing skills through a continuing program of education. Five simultaneous sessions dealt with:

> legal aspects and standards, professional aspects and standards, necessary work climate, basic education processes, and ways in which the profession can increase recognition and acceptance of its responsibility to regulate and upgrade nursing practice.

These discussion sessions were an important part of the conference. Each nurse had the opportunity to exchange ideas, experience and theories related to patient care, and obtain specific ideas for improving her own practice.

A panel of nurses from various areas of practice presented additional information and concepts and served as resource people for the discussions.

Reports and implications for action from the ten sessions were presented on the fourth day. The closing address "The Nurse's Orbit in Relation to Improved Nursing Care," was given by SISTER CHARLES MARIE, C.C.V.I., dean, School of Nursing, Catholic University, Washington, D.C.

More than half the nursing students, over a wide geographical area, had decided on nursing as a career by the time they were 13 years old; many were determined to be nurses by age ten.

These are among the findings of a study, entitled "Career Decisions and Professional Expectations of Nursing Students," which was conducted by the Institute of Research and Service in Nursing Education at Teachers College, Columbia University. Data for the study came from over 4,000 students in schools of nursing and 1,500 non-nursing students in women's colleges.

Students in nursing schools made their occupational decisions at a much earlier age than the non-nursing students in women's colleges. Two-thirds of the nursing students had made up their minds to become nurses by 15 years of age and one-fourth by the age of ten. Only a fourth of the non-nursing students had selected any career by fifteen. This finding highlights the appeal of nursing to girls in their pre-adolescent and adolescent years and the strength of the appeal; the desire to become a nurse is maintained through the junior and senior high school.

The reports suggests that recruitment efforts in nursing might profitably be extended down to the junior high school level.

* * *

When junior is learning to tie shoe laces and fasten buttons, he should not be helped too often when he fails. He will learn more quickly and gain self-confidence if he is allowed to work the problem himself.

Cooperation between Education and Service

SISTER JEANNE FOREST, S.G.M., B.SC.ED.N., M.SC.

The value of a group depends obviously on the individual worth of those who compose it, but even more on that intangible which is called the cohesive force.
— DE CASTELNAU

SERVICE implies carrying out certain functions, the discharge of duty, being helpful to others. It may be service to a neighbor, service to the sick, nursing service. The latter term implies an organized effort and, in its wider sense, embraces the personnel who are involved in the service to the patient, either to cure him if he is ill or to keep him healthy. The nursing profession is truly one of service.

Education can suggest creating or giving life. To develop "the nurse" in the young woman who comes with a life of service as her ideal is a very worthwhile effort. Nurses who devote themselves to this aspect of their profession are far from losing sight of their main objective — service to the patient. They are ensuring the continuity of such service.

Education and service — two distinct entities but so closely related basically that they could not be separated without mutual injury. We educate for service and while serving, education is perfected. Why is it even necessary to bring up the subject of cooperation? We are united within a single profession. Do we not share a common interest in the general public welfare through care of the sick, prevention of illness, development of future nurses? Cooperation in attainment of our common, accepted objective is an ideal to be pursued.

Education *for* Service

The school of nursing has the preparation of nurses for service as its sole reason for existence. The sick are the *raison d'être* for the hospital, just as they are for the school. As long as there are ill people there will be nurses. If medical science ever reaches the stage of eliminating all serious illness, as it presently predicts, and if nurses should become health visitors, then our aims would change. The school of nursing must produce nurses prepared to adapt to an environment in which medical science is steadily progressing and the type of service required is changing.

The student of 1961 will be called upon to serve in all types of environments where devotion and competence will be prerequisites. Education assures the continuity of nursing service. All nurses should be keenly interested in it.

What service is actually required of nurses and how do we see our role in the future? In a brochure entitled *Nurses, Their Education and Their Role in Health Programs,* the Canadian Nurses' Association has answered these questions.

> Broadly speaking, the nurse aids in the conservation, restoration and promotion of the physical and mental health of the individual and the community.
>
> The nurse gives service to:
>
> Patients and their families in hospitals, clinics and homes.
>
> School children and their parents within the school health programs.
>
> Workers and their families within occupational health services.
>
> Parents and their children in maternal and child health programs.
>
> Communities in rural and urban public health services.
>
> What does she do? She gives nursing care in all types of mental and physical illness, at home and in hospitals.
>
> She assists with the rehabilitation of handicapped persons.
>
> She assists with the maintenance of a healthful environment and the control of communicable diseases.

Sister Forest, a member of the faculty of Institut Marguerite d'Youville, Montreal, presented this paper at the Study Day of the A.N.P.Q.

She teaches the principles and practice of the conservation and promotion of mental and physical health.

She administers and supervises all nursing service and participates in planning for health services.

She organizes, administers and participates in the education of professional and auxiliary nursing personnel.

She organizes, administers and participates in activities of professional nursing organizations. These activities include the promotion of legislation for the control of the practice of nursing; the establishment of requirements for registration and of standards for nursing education; and the advancement of the economic welfare of nurses.

Since this is the recognized role for the nurse, it is of the utmost importance that the school of nursing should be a truly educational institution which prepares for such service. It is an obligation that must be recognized by professional and administrative authorities.

Contenting ourselves by responding to immediate needs without thought for the rapid and complex developments in nursing would show an unfortunate lack of foresight and would produce unhappy consequences in the future.

What do nurses see as their future role?

Constantly evolving: The role of the nurse will continue to evolve with social changes, advances in medical practice and developing health programs.

Leadership to increase: She will assume leadership in the development of nursing in all health services and particularly in the coordination of these services. She will give leadership and direction in the education and service of all nursing personnel.

Spirit and service unchanged: It is expected that the nurse will continue to give the same forms of nursing service as at present but with greater emphasis on her function in health teaching and rehabilitation.

Mental health: She will participate more effectively and to a greater extent in mental health programs and in the care of the mentally ill.

Maternal and child health: Her role will be broadened in developing maternal and child health programs, and particularly in the area of the normal growth and development of the child.

More research: She will increase her participation in research to determine the nursing needs of society and the most effective ways of meeting them.

Human dignity: In order to fulfil the role envisaged in the future for the nurse she will continue to bear in mind, the value and the dignity of the human individual.

The pamphlet contains very good suggestions which I commend to you since they go beyond the scope of this article. What has been said suffices to emphasize that nursing education is for nursing service.

Education *through* Service

Psychology teaches us that there are three stages in the learning process: receiving sensory impressions; assimilation and organization of information; use of the information acquired. The student must participate actively in each stage and her learning depends upon the extent of it. The more impressive and realistic the situation, the more inspired she will be to participate.

No purely theoretical, fictitious situation can surpass in effectiveness the clinical field in which contact with patients and their families brings the student face to face with human problems. This part of the curriculum has, quite rightly, been called its heart. To extract full value from it, clinical experience must be carefully planned in accordance with the educational needs of the student. The environment must meet certain conditions without which clinical experience would have little or no value.

To achieve its main objective — total patient care — the hospital must have a sufficient number of qualified nursing personnel. If this condition is met, the student has the opportunity to participate in a program of superior service carried out by competent personnel. She cannot be expected to develop better methods of service than what she sees practised. Good example is essential. The clinical field must offer a sufficiently broad variety of experiences. It is while engaged in actual care of people with these conditions that the student receives her best education. The higher the standards of care that she sees in practice,

the better the opportunity to comprehend the ideal of nursing.

The school of nursing must obviously maintain close rapport not only with the hospital but also with all other health agencies where clinical experience is available so that every nurse may understand and appreciate more fully the preventive aspects of health programs. Public health should be integrated in all aspects of nursing so that the student may put into practice what she learns. The environment must be conducive to learning; the personnel must be competent and interested.

Nursing service holds a vital place in the development of the nurse. No one would contest this fact. On the other hand, nursing education exists essentially for service to the sick and can not attain this objective without the help and cooperation of nursing service.

It is being increasingly recognized that to attain its objective, the school of nursing must control the student's time and organize her experiences in accord with the total program. The tendency to establish so-called independent schools stems from this. However, we must avoid the mistake of believing that nursing service and nursing education can be divorced from each other. The institution has, as its aim, fulfilment of human needs. Education prepares the people who will do this. The value of each entity as well as their interdependent relationship is clearly established. The patient's needs are the personal problem of the nurse. Other aspects may change but not this. On one hand, there is the patient needing care and, on the other, the nurse ready to provide it. Education tends to concentrate on the future; nursing service, on the present. This difference in viewpoint sometimes causes conflict.

Education *and* Service

The two entities must learn to live together with mutual understanding and helpfulness in their quest towards a common objective — better care for patients and improvement in public health.

The means of stimulating cooperation are the same as those advocated for any other group: Meetings, exchange of ideas, common understanding of objectives and the means by which they may be realized. Such cooperation must be present at all levels in the nursing hierarchy. Problems, when they arise, are frequently the fault of poor communications. Someone did not take the time nor the steps to ensure that everyone understood the aims of clinical experience or there was no opportunity provided for exchange of ideas between the faculty of the school of nursing and nursing service personnel.

These conflicts are particularly prevalent in the clinical situation. Who is to be responsible for student assignments? Who is responsible for student supervision and evaluation of her performance? The length of time spent by the student in the service area is a contentious point. Nursing service may maintain that a longer period is required while nursing education takes the stand that the present length of time could be shortened if assignments were chosen more carefully.

Then again, resistance to change on either side can pose problems. Sometimes the simple mention of change by one group is enough to make the other feign ignorance. This results in a lack of cooperation that is highly detrimental to the student's development since she is caught between the opposing forces. We must acknowledge the difference in viewpoints. Nursing education functions for the student, nursing service for the patient. They meet only indirectly.

These difficulties are harmful to good relationships. It is encouraging to know that while the condition may be chronic, it is not incurable. The remedy lies within ourselves and a small amount of introspection will reveal it.

The results of cooperation are well-known. Recalling the necessity for cooperation does not mean that we have forgotten it. We have simply drawn too rigid a line between the aims and responsibilities of our work. There are too many who believe in the absolute separation of nursing service and nursing education, when the contrary is true.

Words alone are useless in bringing about cooperation. There must be understanding of the need for it and

a genuine desire to cooperate effectively oneself and influence others to do the same. This understanding must be inculcated from the very beginning of the educational program in order to consolidate it subsequently within the ranks of nursing service. A united effort is required to attain this aim. The report of the ninth World Conference on nursing noted that nursing in the future would not be the responsibility of individuals but would be a joint undertaking in conjunction with other health workers both within and outside the hospital. In order that nursing care should be what we wish it to be, every member of the team without exception must understand and appreciate the situation as a whole. Each one brings his building-block to the structure. The individual member must know what others are doing, perform his own function and permit others to do the same.

LITTLE TULIP BULB

SISTER MARY CODERRE, R.H.S.J.

When a young student went to the director of nursing education in tears because she was finding that learning to be a nurse was tougher than she anticipated, this allegory gave her new courage. Perhaps it will help others over some rough spots.

ONCE UPON A TIME there was a little Tulip Bulb. She was round and brown, with shiny skin, and not very pretty — just like all other tulip bulbs. She lived in Ottawa, quite near the War Memorial, and one spring, when all the tulips came out in all their magnificent beauty, Little Tulip Bulb gazed at them, and sighed and wept with envy.

"Oh, dear," she cried, "what I wouldn't give to be as beautiful as one of those tulips!" And she looked at her plain little self, and cried in discouragement.

But God heard her, and He bent down and spoke to her. "Little Tulip Bulb," He said, "from all eternity I have planned your destiny — and it is this: that you should sing and sway in the spring sunshine, and thus give glory to Me!"

Little Tulip Bulb was so happy when she heard this. "Oh, Heavenly Father," she cried, "that is what I want — more than anything in the world! Please hurry and make me into a beautiful tulip. I think I would like to be a red one, please, because red is for love, and," she added shyly, "I do love You — so very much!"

God smiled at her kindly, and said: "And I love you, Little Tulip Bulb. But I can't hurry and make you into a tulip. It is a long, slow process, and you have to do most of it yourself — with My help, of course. You may not like the process. You may find it painful and lonely. But it's the only way you can turn into a tulip."

"Oh, Heavenly Father," said Little Tulip Bulb, "I'll do anything — anything! Please, show me what I am to do!"

"Well," said God, "I'm going to turn you over to a gardener — one who has had years of experience in cultivating tulips. All you have to do is to subject yourself to this gardener. He knows just what to do for you."

"Oh, thank you, Heavenly Father," breathed Little Tulip Bulb gratefully. "Thank you a million times for choosing me to be a tulip!"

Time passed. It was autumn. Little Tulip Bulb was growing impatient. Then, one bright autumn day she felt herself being lifted up. The kindly face of the gardener smiled at her. Then he said: "My! what a nice fat little bulb

Formerly Associate Director of nursing education at Hotel Dieu Hospital, Kingston, Ont., Sister Coderre is now Assistant Mistress of Novices at her Order's Novitiate.

this is! I must plant her right near the gate where everybody will be able to see her."

He took Little Tulip Bulb outside, dug a deep hole in the rich brown earth, dropped her in gently and covered her all up tightly. Little Tulip Bulb was amazed, and hurt, and very scared, and lonely. What was the meaning of all this? It was so dark, and cold, away down there all alone. She cried out to the gardener, but her voice was muffled. Not only was she covered with earth — but also with some vile-smelling stuff called fertilizer (this was adding insult to injury!) — and a thick layer of dead leaves — and some brown sacking.

Oh! this was indeed too much! The gardener must have made a horrible mistake! God had said she would be a tulip, swaying in the spring sunshine — not this overwhelming cold darkness!

Poor Little Tulip Bulb! How she cried! How she tried to kick and rebel, and get out of the black hole she was in. Then she grew too weary and discouraged to cry any more.

It was at this point that she thought of God. Perhaps He could still hear her and help her, if she called on Him. So she did. And sure enough, His voice answered, very softly and reassuringly, "Don't cry any more, Little Tulip Bulb. This is all part of my plan — part of the beautifying process. Do you still want to be a tulip? Or do you want to remain a plain little bulb all your life?" "Oh yes, God," said poor Little Tulip Bulb between sobs, "I do want to be a tulip. It's just that I'm afraid — and so alone here in the dark."

"Trust Me, dear Little Tulip Bulb," said God. "I will never leave you." Then He added something very strange, which Little Tulip Bulb couldn't understand. He said, "Unless the grain of wheat, falling into the ground, die, itself remaineth alone. But if it die, it bringeth forth much fruit."

The time passed slowly. The days grew colder. Little Tulip Bulb couldn't see any end to her imprisonment. But she had promised God she would trust Him — and she did.

After what seemed an eternity of uselessness and nothingness — of just lying there in the dark waiting — suddenly Little Tulip Bulb felt new life surging through her. She felt herself pushing upwards through the brown earth. She could feel warmth, like the sun, seeping through to her, and refreshing draughts of clear spring rains. She could feel herself growing and growing — and she was overcome with a strange new happiness.

One fine day it happened! She poked her little nose right through the brown earth and looked out into the bright sunshine, up to a blue sky. Beside her, a fat robin cocked a bold eye at her, and pulled on a juicy worm. A child chuckled and gurgled exultantly, crying "Look Mummy, the tulips are up!"

There were more days of stretching lazily in the warm sunshine and drinking in the delicious spring rain. Then, one day, she felt herself unfold completely. She could feel the sun shining through her petals. The gardener's kindly face bent over her admiringly as he said, "This is the most beautiful tulip in my whole garden. Such a delightful color — red, the color of love!"

God bent down and said: "Dear beautiful tulip, you have fulfilled your destiny. You are giving me glory, the way that I planned you should. I am very proud of you!"

Little Tulip Bulb — oh, excuse me — I mean Beautiful Red Tulip was so happy she cried. But it didn't matter because the tears looked like dewdrops and only enhanced her beauty. She told God how sorry she was for being such a drip when He knew what He was doing all the time.

She swayed and sang in the spring sunshine and everybody who passed by exclaimed, "Did you ever see such a beautiful tulip! And such color — the color of love!"

There is no duty we so much underrate as the duty of being happy.

— R. L. Stevenson

A series of articles on how to study gives as the first step "Pick up the book." After that, it's all downhill.

More About the Extension Course

KATHLEEN RUANE

A UNIQUE OPPORTUNITY for nurses to improve their management skills by means of a home study program is being offered in September 1961. It is the extension course in ***nursing unit administration.*** This course has been prepared to meet the needs of nurses who wish to improve their administrative skills but who, for one reason or another, are unable to attend a universiy. Head nurses, assistant head nurses, supervisors and directors of nurses in small hospitals who lack previous formal preparation in nursing service are eligible for enrolment.

The main part of the course content will be given by correspondence, a method used for several years in business, technical and academic fields. Combined with the home study section will be two five-day intramural sessions or workshops. It is felt that a "meeting of minds," where active discussion and participation occur, is highly conducive to learning in adult education. The first workshop next September will introduce the students to the program and provide a general over-view. Subjects such as communications; social changes affecting nursing; qualities of leadership; and study habits will be presented through films, group discussions and outstanding speakers. The final workshop in May 1962, will be concerned with budgeting, human relations in personnel management and problem areas presented by the students. In order to minimize travelling time and expense, the workshops will be held on a regional basis, two in the Western provinces, three in Ontario and Quebec and one in the Atlantic provinces.

The first lesson will be mailed in October, 1961, following the initial workshop. The student will receive a total of 13 lessons at two-week intervals until the middle of April. The lessons will present topics of vital importance to the nurse who is responsible for the care of the patients in her unit. The fundamentals of administration, planning, organizing, coordinating, directing, communicating and controlling will be considered. An examination of the nursing service department with regard to its structure and function will help the student to recognize relationships and lines of communication existing within the hospital.

How does the head nurse assign staff?

What use is made of reports, rounds and work plans?

How do physical facilities, equipment and supplies affect the nursing care of the patient?

These are questions that are discussed in lessons on the administration of the nursing unit. Evaluation of patient care; supervision of personnel; in-service education; the legal aspects of nursing; the organization and control of hospitals and the philosophy of patient care, will be studied.

Attached to each lesson will be reprints of pertinent journal articles, a list of reference reading to amplify the lesson and an assignment. The reference reading will be assigned from textbooks purchased by the student. Each assignment or exercise will be planned to help the student relate the principles learned through the lesson material and reference reading to the actual job situation. The assignment will be carefully marked by an instructor. If the student appears to have difficulty with a particular phase, the instructor will provide assistance by adding appropriate comments when returning the exercise to the student.

The extension course in nursing unit administration, through intramural and extramural sessions, attempts to achieve three broad objectives. These objectives are to assist the head nurse to:

1. Improve patient care through the application of basic principles of administration to the management of a nursing unit;
2. develop an understanding of the administrative function inherent in her position;
3. assist the head nurse to co-ordinate the service of the nursing unit with the

services of other departments effectively through improved methods of organization and communication.

It is evident that a course of this nature has limitations in comparison to university courses. It is not a substitute for university study. Rather, it is on-the-job training designed to improve the nurse's skill in the application of administrative principles to the management of the nursing unit. A better understanding of the head nurse's function and responsibility should lead to improvement in service to the patient, and to greater job satisfaction for the nurse.

The cost of the course is $100 for tuition, payable not later than July 15, 1961; $20-25 for textbooks, the expenses involved in travelling to and from the workshops plus maintenance during the two five-day periods. A calendar containing additional information is available to prospective students on request.

A statement of confirmation signed by the director of the course will be sent to the student on successful completion of both the intramural and extramural sessions. The course is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association. The W. K. Kellogg Foundation has given financial support to the program for a four-year period.

Applications for enrolment should be made not later than June 1, 1961. Applications and enquiries regarding the course should be directed to:

Director
Extension Course in Nursing Unit Administration
25 Imperial Street, Toronto 7, Ont.

In Memoriam

Marion (Cofell) Bellyou who graduated from the Public General Hospital, Chatham, Ont. in 1934, died October 28, 1960 in Trenton, Ont.

* * *

Elizabeth (Ong) Bergeron who graduated from Hôtel Dieu Hospital, Windsor in 1951, died recently.

* * *

Ruby June (Knutson) Dods, a graduate of Misericordia Hospital, Winnipeg in 1949, died suddenly on February 28, 1961 in Nanaimo, B.C.

* * *

A. (Belcher) Weir Douglas, a graduate of Medicine Hat General Hospital, Alberta died in February, 1961. She was awarded the Order of the British Empire for her work among the Indian people of the Northwest Territories during the 1930's.

* * *

Muriel Gaulin, a graduate of Sherbrooke Hospital, Sherbrooke, P.Q. in 1937, died in Sawyerville, P.Q. on February 8, 1961. Following her graduation she served on the staff of the Royal Victoria Montreal Maternity Hospital for about seven years. She returned home to take over family responsibilities.

* * *

Ursule Gingras, a graduate of Hôpital St. Francois d'Assise, Quebec, died October 12, 1960.

* * *

Patricia (Walton) Glauser, a graduate of Winnipeg General Hospital in 1936, died on February 7, 1961 in Vancouver.

* * *

Isabel (Sutherland) Hartley who graduated from Victoria Hospital, Winnipeg in 1926 died in a car accident in Vancouver, in February, 1961. She was a former night supervisor of the North Vancouver General Hospital.

* * *

Florence (Duchene) Janisse, a 1911 graduate of Hôtel Dieu Hospital, Windsor died recently.

* * *

Gwladwen Jones, who graduated from Toronto Western Hospital in 1927 died in Toronto on February 10, 1961 after a long illness. She had been associated with T.W.H. for over 30 years, most recently as nursing education coordinator.

A native of Wales, she came to Canada in 1912 and, in later years, took a prominent part in nursing in Ontario. At one time she was secretary of District 5, RNAO and president of the University of Toronto School of Nursing alumnae association. She

(Continued on page 469)

Neurological Evaluation of the Child

WANDA SCHIFFMANN, M.D.

This is the concluding portion of a study of the young child in relation to his neurological development.

THE DEVELOPMENT of neuromuscular activity, beginning with the initial phase of automatism to the final stage of intentional, objective and coordinated action is extremely interesting. Aquatic activity, the reactions of the baby when immersed in water, gives valuable information. However, since such a study is frequently impractical and not practised, only those neuromuscular conditions encountered under ordinary conditions will be considered.

Postural Adjustment

Holding an infant in an unnatural position stimulates adjustment reactions that vary according to the different stages of his development. For example, if the child is held head down, his reaction will vary according to the particular phase of growth.

a. The *newborn phase* reaches its maximum during the first month, then regresses and disappears completely around the fifth month. It is characterized by generalized flexion and is probably under subcortical control.

b. The *phase of extension* makes its appearance with the decline of the newborn phase. It reaches its maximum at four to six months, then regresses and disappears completely at one year of age. It is characterized by extension of the head and trunk and is dependent upon the development of musculature for this purpose.

c. The *phase of balancing* is seen from eight to 18 months. The child is conscious of his position and his emotions come into play. Often he will cry. He reacts with flexion which is different from that found in the first phase. He clutches his thighs and tries to right himself through deliberate efforts. At this stage there is cortical control over voluntary movements and, at the same time, there has been maturation of interconnecting brain pathways.

d. The *phase of maturity* may appear prior to the end of the first year but is not usually seen before 18 months of age. The child takes the situation into account and has sufficient cortical control over flexor and extensor muscles to adopt whatever position he wishes. Most of the time there is neither flexion nor extension since the child considers his position as a game.

Rolling over

a. In the *newborn phase*, the human is distinguished from other species by his inability to roll from the supine to a prone position. However different muscular groups can come into play so that the child succeeds in rolling from a dorsal to a lateral position. This motion involves a bodily rather than a segmental response. It lasts to the sixth week of life.

b. The *phase of spinal extension* is present for several weeks, regressing at the end of two months. It is characterized by activity of the extensor muscles, particularly those in the back.

c. The *phase of automatic rolling* is seen at about the same time as the preceding one and lasts several weeks more. Movements become more integrated with a certain automatic quality that suggests their subcortical origin.

d. The *voluntary phase* develops at the beginning of the sixth month and persists later. In contrast to the preceding phase, movements have a deliberate intentional quality that demonstrate some active participation of the cerebral cortex in the initiation of movement and action.

Horizontal Locomotion

a. The *newborn phase* is characterized by flexion of the extremities with the head held close to the body. The activity depends on the varying degrees of tension found in the different muscle groups.

b. The beginning of *spinal extension* marks the start of the development of

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Dr. Schiffmann is a neurologist on the staff of Hôpital Ste Justine pour les enfants, Montreal.

extensor function. It begins in the cervical area after the 10th day.

c. *Advanced spinal extension* comes about through advance in the cephalocaudal intelligence and extends to the lumbar area. There is already a certain degree of control over rotary movements in posture. The child succeeds in raising his head and the upper part of his body. He is able to maintain a desired position. Extension of the fingers replaces flexion.

This particular phase occurs around two months of age or slightly after and is followed closely by the next two stages.

d. The phase of endeavoring to move the upper part of the body.

e. The phase of endeavoring to move the lower part of the body.

f. The *all-fours position* is seen at a variable age, usually beginning at six months. It represents integration of control of postural muscles in the scapular and pelvic areas.

g. A phase of *deliberate but unorganized progress* may coincide with the previous one or follow it closely.

h. A phase of *deliberate, organized progress* succeeds the preceding ones at a variable interval of time. It is not unusual to see a child, who seems to be making no progress in crawling, suddenly get up and walk. During this phase the child adopts a definite way of crawling. The classical one is a coordinated movement of the upper and lower extremity on the same side, with the knee being advanced as the palm is moved forward.

i. Finally, the *phase of integrated advance* is seen. This usually lasts to the end of the first year. The upper limb on one side, the lower limb on the opposite side become synchronized in movement. During this time the nerve centres of control complete their organization into a single system.

Development of the Sitting Position

This must be considered under two separate headings: 1. Rising 2. resistance to gravity.

a. The *newborn phase* is characterized by no resistance to the force of gravity. In that sense, the baby is completely without resources.

b. The *orthotonic phase* is present when the head can be balanced and does not drop passively in the direction of gravity.

c. The phase of *voluntary flexion* movements is seen later as the child attempts to sit up. It coincides with lack of resistance so that when the child is placed in a sitting position his head and trunk fall forward between his legs.

d. The baby becomes capable of sustaining a *half-sitting position* by using his upper arms in extension.

e. The baby pushes himself up from a ventral position.

f. The baby pushes himself up from a dorsal position. He turns himself to one side, resting on a half-flexed arm.

g. The child is able to sit up without help using a single, smooth movement. This phase more or less coincides with the one in which the child can roll from the supine to a prone position.

The Vertical Position and Normal Walking

a. In the *newborn phase,* the baby is passive when held in a vertical position. His head is up. If the soles of his feet touch a solid surface, automatic walking movements can be seen.

b. The preceding response becomes inhibited in two or three months and is succeeded by a *static phase.*

c. A *period of transition* follows.

d. Starting around six months, usually at eight or nine months, the baby can maintain a *standing position.* This is achieved through development of extensor muscle functions. The child still needs to grasp something for support.

e. The phase of *isolated steps.*

f. The phase of *independent steps* follows quickly. The child has not yet adopted a definitive way of walking. He places his feet flatly on the ground, has an irregular rhythm and aimless manner of walking.

g. He develops the *heel-toe movement.* The heel of one foot touches the ground as the heel of the other is raised so that balance is maintained on the toes. Walking remains irregular in rhythm and the baby's equilibrium is defective for some time.

Grasping

Development of a grasp is part of the picture of the development of voluntary motility. At the same time it provides an excellent means for observing sensory development. For

grasping to take place, an exterior sensory stimulus is required. The most practical method of studying grasping action is to relate it to visual development.

a. During the *newborn phase* there is no appreciable response.

b. The phase of *objective vision is* seen, especially towards the end of the second month. Fixation, convergence and accommodation without muscular movements in the direction of visual stimulus are characteristic qualities at this stage. The baby discovers his hands and makes his first efforts toward manipulation.

c. The *visual-motor* stage occurs about the fourth month. The response is compulsive but purely automatic. There are ataxic movements. The child judges distance poorly in attempting to grasp the object. Although manual predominance can be recognized at this stage, movements are bilateral. At the start of the grasping movement, the fingers may be in extension but this position is not maintained. The fingers are flexed again as the arm is extended and the closed fist touches the object.

d. A phase of *deliberate manipulation* starts at the eighth month. This indicates the beginning of cortical dominance over function. Movements are not necessarily bilateral. The child can carry out grasping movements with one hand only.

Movements are more coordinated and directed. There is better judgment of distance. The fingers remain extended throughout the movement. Thumb to finger apposition is efficient. The child is able to grasp an object with his fingertips. Characteristics of this phase are the great deliberation in carrying out a movement and the intent concentration of the child.

e. A phase of *coordinated grasping* succeeds. The child sees the object and quickly judges the essential factors before the grasping motion begins. Non-essential movements become progressively less.

f. This is followed by *mature grasping*. The fingers are extended only as they come near the desired object.

The Function of Language

This part of the examination of a child is very difficult. It can only be carried out with some degree of certainty at two years of age. The child vocalizes in a variable manner beginning at one to two years of age. The sounds, at first, are a sort of gurgling. Then they become tongue sounds and finally, lip sounds repeated in a monotonous or musical way.

Around 10 months of age, the child can understand a few simple commands. At about one year of age, sounds are integrated into distinct words. The vocabulary develops so that at 18 months the child can pronounce at least half a dozen words clearly. He understands sufficiently well to carry out a few simple requests. At two years of age, words are integrated into short phrases. The child can express himself quite understandably. To detect the presence of aphasia or related problems such as apraxia (impairment in the ability to use objects correctly) or dysarthria (impairment in the ability to speak), it is necessary to note the competency with which words are formed, sounds articulated; the extent of the vocabulary; the capacity to understand the spoken word through carrying out simple commands. With the older child or the school child the written word can be used. The child can then be evaluated in regard to his ability in writing, copying, and reading. Of course, individual levels of intellectual development and education must be taken into consideration.

Aphasia can be studied under four main groups:

a. Aphasia related to peripheral deafness (a lesion of the auditory nerve or in the middle ear).

b. Aphasia related to a demonstrable, central organic lesion in either the motor or sensory area.

c. Aphasia without a demonstrable organic lesion, purely functional in nature, related to a "deficient quality" in the nerve cells of the area in question.

d. Aphasia related to a serious psychic disorder where the child can hear, understand, and is capable of replying or forming words but refuses to do so.

Manual Dominance

This is frequently a difficult question to resolve. Information given by the parents is valuable but sometimes inaccurate. Hereditary and familial tendencies are of prime importance.

The problem of manual dominance is related to the problem of aphasia.

Although in the young child it is not possible to judge the existence of aphasia objectively, one may foresee its existence, or at least, the possibility of retardation in speech. For example, if the child is congenitally right-handed then we know that the left brain hemisphere is dominant and the speech centre is located there as well. A right-sided hemiplegia in such a child indicates injury to the dominant hemisphere. It then becomes possible to foretell or to trace speech difficulty. It is very important to identify the dominant side of the brain. The tendency for the right-handed person to become left-handed in the face of neurological lesions confuses the picture.

An interesting rule to follow, although not always an accurate one, is to determine manual dominance according to the hair whorl. According to the researchers who reported this information if the crown is to the left of the median line or sagittal suture, the subject is normally right-handed; if to the right, the subject is left-handed. If there are two crowns, the subject may be considered ambidextrous. Education and environment may result in right-handed dominance. If it is squarely on the median line, the subject should be considered ambilateral. Again external factors will determine manual dominance. These facts and unusual conclusions are based on a 10-year study of more than 800 subjects from birth to five years of age and on 500 subjects over five years old.

Conclusion

In summary, the results of a neurological examination of the young child will vary considerably depending upon his stage of development. These variations arise from age, environment, sex, race and state of general health.

Each phase in development bears some relationship to the one immediately preceding or following it. The development of each function represents a corresponding period of maturation in subcortical control as related to the beginning of cortical control. Finally, the integration of the various nerve centers into a single system is indicated through intentional, organized and regular action.

Apart from the ordinary routines of examination, a study of development must record attitude, posture and spontaneous reflex activities at various stages.

The *first month,* the newborn phase, is characterized by passivity. The infant cries in response to a disagreeable stimulus or sensation. His protests are accompanied by generalized motor activity. Spontaneous movements are bilateral, symmetrical. Living on his face, he can raise his head and turn it to either side. His fists are clenched. The baby sleeps 18-20 hours a day during this period. Tendinous reflexes are present but diffuse. Cutaneous plantar reflexes are displayed either through flexion or extension during the first days of life, then by extension. Cutaneous abdominal reflexes are present only in 30 per cent of babies and are diffuse. "Rooting" and sucking reflexes, the Moro reflex, grasping, tonic neck reflexes and vestibular reactions are all present.

During the *second month,* the child cries with tears. He sleeps just as much. He can smile. Visual fixation is developed to the point that he can recognize his mother. Auditory stimulus produces rotation of the head and eyes in the direction of the sound. The baby can hold his head erect for several minutes. In addition to the reflexes present during the first month, middle ear reflexes appear.

In the *fourth month* the baby sleeps 16-18 hours a day. He begins to sleep without waking at night. His grip develops to the point where he attempts to grasp objects that please him through sight or sound. He sees his mother, recognizes her voice. Lying on his back, he can raise his head and he tries to participate actively when we want him to sit down. His fingers are no longer clenched. Reflexes of balance begin to be demonstrable. Grasping and Moro reflexes are greatly diminished if not totally absent.

At *six months,* the baby ordinarily sleeps 15-16 hours daily, including a nap in both morning and afternoon. He plays with his hands, his feet and his toes. He vocalizes a great deal and shows affection towards other persons than his mother. He rolls over easily

and can sit alone but his equilibrium is still uncertain. Held in a standing position, he attemps to maintain it. Intentional grasping is carried out with thumb to finger apposition. Cutaneous abdominal reflexes are adult in nature. "Lifting" and "falling" reflexes are fully developed.

At *eight months,* the child can utter a wide variety of sounds. His responses are developed to the point where a few conditioned reflexes can be stimulated. He sits down easily and starts to crawl on all fours.

At *ten months* he can stand but falls down easily. If supported he can take a few steps. He begins to say a few words and can understand a few simple commands.

The *one-year-old* is able to walk a few steps and imitate sounds. He has a vocabulary of elementary words. He recognizes favorite playthings. It is around this age that he begins to give up one of his daily naps. He sleeps 14-15 hours. The sucking reflex disappears and the Landau reflex is present.

At *18 months* walking is well-developed and voluntary movements are coordinated to the point where the child can eat and drink without a mess. He understands almost everything said to him, uses words to express himself and cries readily if frustrated.

At *two years* of age the child is spoiled in spite of the parent's efforts to avoid it. He knows what he wants, runs about everywhere, speaks freely, although not necessarily always understandably. The standing position, beginning from a horizontal or seated position, is achieved in an adult way. Plantar reflexes tend towards flexion and, if in extension, are of the Babinski type of response. Tonic neck reflexes regress. The child who has not started to walk nor talk at this age should be considered as having a pathological condition and requires care.

After two years of age, mental and emotional development has special significance. At six years, the neurological examination of the child is essentially the same as for an adult.

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THE PROVINCES REPORT

The Executive Committee of the Canadian Nurses' Association held its 197th meeting, February 16-18 inclusive. Generally speaking, the emphasis appeared to be on future planning in the light of the findings of the Pilot Project and other factors that affect nursing such as the present hospitalization schemes. The ever-increasing demand for nursing services is reflected in the efforts being made by the provincial associations to bring the formerly inactive nurses back into the active fold through refresher courses. The swing towards provision of home care has instigated special projects or special services to make this possible. Acceptance of the fact that nursing auxiliaries are needed to augment present nursing services is concentrating attention on the preparation of these people and definition of their duties to avoid possible conflict. Canadian nurses are in the midst of a process of thoughtful consideration of what the future holds for them.

Alberta

1. Increased its fees for active membership to $25.

2. Is participating in a nursing care study initiated by the Hospitals Division of the provincial government, with the objective of obtaining a basic staffing pattern.

3. Sponsored a pilot project on home care that gave training to 250 individuals in home nursing and first aid. The classes were conducted by public health nurses in the areas involved.

4. Set up a scholarship fund to provide financiel assistance to student nurses with funds provided by dominion-provincial grants.

British Columbia

1. Increased the funds available in the educational fund.

2. Co-sponsored a refresher course with the Vancouver General Hospital to prepare inactive nurses for active duty. An effort is being made to determine the best type of course for this purpose.

3. Is concerned about the deteriorating ratio of nursing to auxiliary staff as a result of B.C. Hospital Insurance Services budgetary policies. This concern is related to nursing education and standards of nursing service.

4. Is pleased with the results of bargaining on a provincial basis in relation to employment relations.

Manitoba

1. Has carried out revisions in many areas such as in employment policies, policies and standards for schools of nursing, registration and examination policies.

2. Cooperated with the Associated Hospitals of Manitoba and the Advisory Council for Licensed Practical Nurses in preparation of a recommended course for hospital aides.

New Brunswick

1. Upgraded admission requirements to schools of nursing.

2. Is revising minimal standards for its schools of nursing.

3. At the request of the New Brunswick Hospital Association is assisting in the preparation of job descriptions for the various categories of staff concerned with nursing.

4. Offered a wide variety of institutes and refresher courses.

Newfoundland

1. Plans to use NLN Test Pool examinations this fall.

2. Revised its suggested personnel policies.

3. Studied registration policies and increased the period of psychiatric affiliation.

4. Studied policies in relation to setting up a new school of nursing.

Nova Scotia

1. Carried out a survey of schools of nursing for the purpose of evaluation and possible approval.

2. Announced that under its Nursing Assistants' Act, graduates of nursing assistants' schools must hereafter write examinations to obtain registration.

3. Announced the pending organization of a two-year program at the Halifax Infirmary School of Nursing.

4. Reduced the required affiliation period in tuberculosis nursing for student nurses.

Ontario

1. Is awaiting further developments in regard to the proposed College of Nurses.

2. Increased the amount in the Permanent Education Fund that supplies loans to nurses for university preparation.

3. Reported on the pilot home care program being carried out in Toronto.

4. Cooperated with the Ontario College of Physicians and Surgeons and the Ontario Hospital Association in studying medical procedures carried out by nurses such as intravenous infusion and medication, blood transfusion, blood withdrawal, administration of anesthetics. These measures have been approved for nurse administration following special instructions issued by the College and the RNAO.

5. Held a number of conferences and institutes that included one for directors of nursing — the first of its kind.

Prince Edward Island

1. Has made revisions in its examination policies, legislation and bylaws and recommended changes in personnel policies relating to nurses' salaries.

2. Is sponsoring a study of provincial nursing service requirements.

3. Is organizing a nursing assistants' association.

4. Is studying ways and means of improving present school of nursing programs.

5. Has implemented recommendations related to full salary compensation for nurses attending university courses and institutes; provision of salaries for personnel replacements for those undertaking advanced study; increased salaries for nurses.

Quebec

1. Expressed concern about the role and preparation of the nursing assistant.

2. Noted that the University of Montreal is currently considering the contribution that might be made to nursing through establishment of a basic school of nursing.

3. Commented on efforts being made by other university facilities to provide postgraduate preparation for nurses on a part-time basis through extension programs.

4. Is anticipating revision of admission requirements to both English and French schools of nursing if changes in the provincial educational program come into effect.

5. Is considering the possibility of acquiring its own premises.

Saskatchewan

1. Increased the annual registration fee for active membership to $22.

2. Approved the appointment of a full-time adviser to schools of nursing.

3. Raised the minimum educational requirements for entrance to schools of nursing, to become effective after January, 1963.

4. Completed arrangements for a professional liability insurance policy available to all its members.

(*Continued from page 461*)

held certificates in teaching and supervision and in public health nursing from U. of T. Her loyalty and dedication to her profession will be long remembered by her friends and associates.

* * *

Edith Augusta Prudence Moody who graduated from Verdun Protestant Hospital, P.Q. in 1930 died on February 8, 1961.

* * *

Alice Laverne (O'Brian) Pratt who graduated from Souris Hospital, Manitoba in the early 1930's died on January 21, 1961. She was supervisor of Souris Hospital for a number of years.

* * *

Margaret Jean (Sharpe) Sutherland, a graduate of Garfield Park Hospital, Chicago, Ill. in 1924 died in Woodstock, Ont. on March 4, 1961.

* * *

* * *

Vivian Joyce (Wilton) Tebby, a 1947 graduate of Strathroy General Hospital, Strathroy, Ont. died on January 23, 1961 from injuries received in a car accident earlier in the month.

* * *

Jessie (Potts) Waddell, a graduate of the Lady Stanley Institute, Ottawa in 1907 died suddenly on December 20, 1960.

* * *

Doris Edna (McLeod) Wagner who graduated from Regina Grey Nuns' Hospital, Sask. in 1946 died on January 2, 1961 from injuries received in a car accident.

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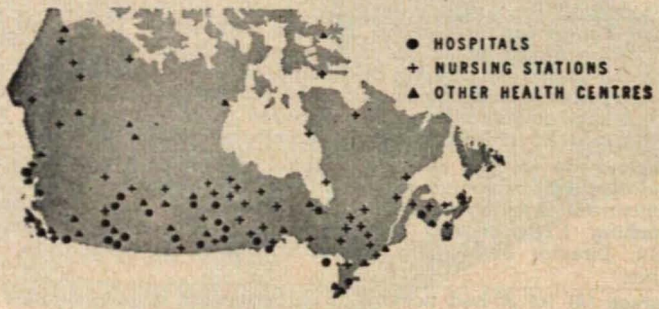

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(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

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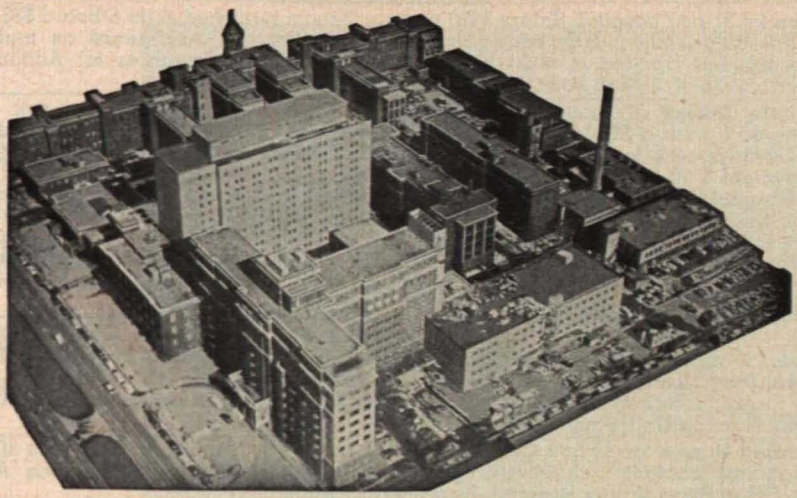

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Registered Nurses for General Duty & Operating Room for 100-bed hospital. Nfld. Government salary plus $150 bonus end each 6-mo. service. 2-wk. paid vacation after 1-yr., 8 statutory holidays, one-way transportation paid. Apply to: Nurse-in-Charge, Notre Dame Bay Memorial Hospital, Twillingate, Newfoundland.

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Registered Nurses for General Duty for 21-bed hospital. RNA of Nova Scotia policies in effect. Apply: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbor, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

ONTARIO

Director of Nursing for modern 75-bed hospital. Attractive growing town of 5,500. Starting salary dependent upon qualifications & experience. Please enclose references, give full particulars & date available in letter to the: Secretary, District General Hospital, Dryden, Ontario.

Supervisor & Public Health Nurses (Qualified) for Waterloo County generalized program in a new Health Unit to open July, 1961. State salary expected. Write: Mr. C. H. A. Stager, County Clerk, Court House, 20 Weber Street East, Kitchener, Ontario.

Supervisor (evening & nights) for 160-bed hospital, 5-day wk., excellent personnel policies. Hospital of Ontario Pension plan, residence accommodation available, assistance with transportation can be arranged. Apply: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario.

Instructor - Clinical with postgraduate university work for active Medical floor, beginning July, 1961. 53-students, hospital expanding to approximately 300-beds. — Services segregated, good personnel policies. Apply: Director of Nursing, General & Marine Hospital, Owen Sound, Ontario. (Georgian Bay Area.)

Nurses for Nurses' Technician Team (Intravenous & Intramuscular Therapy, Venepuncture etc.). 40-hr. wk., shift work. Good personnel policies. Apply: Assistant Administrator (Medical), Ottawa Civic Hospital, Ottawa, Ontario.

Registered Nurse, fully qualified as **Supervisor** for newly renovated Obstetrical Department in Northern Ontario. Salary $350, personnel policies, pension plan. Contact: Directress of Nurses, Misericordia Hospital, Haileybury, Ontario.

Registered Nurses $300 per mo. min. to max. $340, 3-weeks vacation with pay, sick leave after 6-mo. service. Non Registered — $15 less. Cert. N.A. $210 min. to max. $240, 2-wks. vacation with pay, Non Certified Cert. N.A. $200 to max. $230. Increases for both groups $10 per mo. after 1-yr. on staff. 9-statutory holidays. All staff:— 5-day 40-hr. wk. Apply: Superintendent, Englehart & District Hospital, Inc., Englehart, Ontario.

JEWISH GENERAL HOSPITAL

MONTREAL QUE.

NURSING OPPORTUNITIES

In this modern 400-bed non-sectarian hospital for: Head Nurses • Instructor • Staff Nurses • Certified Nursing Assistants.

• Openings in all Clinical Services • Excellent personnel policies • Attractive residence accommodation available • Bursaries for post-basic courses in Teaching and Administration.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL, 3755 COTE ST. CATHERINE ROAD, MONTREAL, QUE.

THE SARNIA GENERAL HOSPITAL

OFFERS EXCELLENT OPPORTUNITIES FOR

REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

The hospital is modern, fully approved (J.C.A.H.) with plans for an expansion program to be completed over the next five years.

Sarnia is a rapidly growing city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a summer resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

Excellent benefits include a 40 hour week, regular rotation of shifts with premium pay for evenings and nights.

SALARY SCHEDULE:

for Registered Nurses — $280 per month to $332 per month

for Certified Nursing Assistants — $192 per month to $218 per month

Apply to:

PERSONNEL DIRECTOR, SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

Registered Nurses for new modern 15 (Medical & Surgical) bed hospital in the heart of the Niagara Fruit Belt, 12-mi. from Niagara Falls. Operating room experience desirable. Apply stating qualifications, expected salary, date available & telephone number to: Administrator, Medical Centre Hospital, Box 10, Virgil, Ontario.

Registered Nurses for 60-bed hospital. Salary $280 per mo. gross. Good personnel policies. For further particulars apply: Superintendent, St. Marys Memorial Hospital, St. Marys, Ontario.

Registered Nurses, Certified Nursing Assistants for modern 75-bed hospital. Starting salary: R.N.'s $300 per mo. with merit increases after 6-mo. service, C.N.A.'s $216 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing District General Hospital, Dryden, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $300 & $210 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospital of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for immediate & future vacancies in this 42-bed hospital. Starting salary $300 & $210 respectively. Accommodation in new residence. Deduction for room & board $40. Pension plan available & other benefits. For full information apply to: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses for General Duty (2) urgently needed for 48-bed hospital. Highest salary paid. Telephone 378 or reply to: The Administrator of St. Joseph's General Hospital, Little Current, Ontario.

Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty in modern 40-bed hospital in resort town on beautiful Lake Huron. Starting salary $285, 40-hr. wk., 10 working days sick leave in 1-yr., 50% unused sick leave paid in cash at end of year. 50% single OHSC premium paid, 8 statutory holidays, 4-wks. vacation after 1 year, board & room $30, modern living quarters. Transportation allowance after 1-year service. Apply: Superintendent, Saugeen Memorial Hospital, Southampton, Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital, in iron mining town, 150-mi. north of Sault Ste. Marie, Ontario. Starting salary $281 min. to $316 max. for experience, less $20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $285 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered General Duty Nurses (Immediately) for modern 162-bed General Hospital. Starting salary $275, 40-hr. wk., 8 statutory holidays, O.H.A. pension plan & sick leave benefits. Stratford is an attractive city of 20,000, within easy reach of larger cities. Apply: Director of Nursing, General Hospital, Stratford, Ontario.

Registered Staff Nurses for Operating Room Department: A new, well equipped unit; rotating hours of duty; attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses & Certified Nursing Assistants for modern 50-bed active hospital. 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $285, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

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Modern Hospital and School of Nursing

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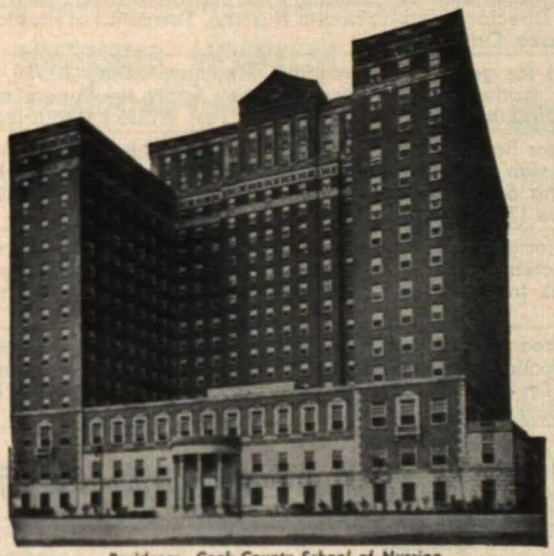

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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$345-$385* for a *37½ hour week*. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $285 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $285 per mo. with recognition for P.G. courses, 40-hr. wk. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; $285 gross. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for 350-bed General Hospital located in downtown Toronto — Rotating hours of duty, attractive personnel policies, in-service education program. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Public Health Nurses (qualified) for an expanding urban-rural Health Unit. Personnel policies on request. Apply to: Director of Nursing, Simcoe County Health Unit, Court House, Barrie, Ontario.

Public Health Nurses (Qualified) for generalized program. Minimum salary $3,700, annual increments $150, liberal transportation allowance & other benefits. Apply to: A. E. Thoms M.D., Director, Leeds & Greenville Health Unit, Brockville, Ontario.

Public Health Nurses (Qualified). Salary $3,500 - $4,500; annual increment $200, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Box 337, Cobourg, Ontario.

Public Health Nurse (Qualified) for a generalized program in Etobicoke Township. Minimum salary $3,925. Car allowance $670 per annum. 4-wk. vacation after 1-year. The usual employee benefits. Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Road, Etobicoke, Ontario.

Public Health Nurses (qualified) for generalized program. Minimum salary $3,750 with annual increments & allowance made for experienced nurses. Apply to: Supervisor of Nursing, Fort William & District Health Unit, 900 Arthur Street, Fort William, Ontario.

Public Health Nurse (qualified) for Red Lake, Ontario. Salary $3,790 with 5 annual increments of $175, car provided, pension plan, provision for sick leave & holidays. Red Lake is in the center of a gold mining & tourist area. Apply to: Dr. E. R. Langford, M.O.H., District of Kenora Health Unit. Box 174, Kenora, Ontario.

Public Health Nurses (qualified) for generalized program including some bedside nursing. Salary $3,500 with 10 annual increments of $200. Employer shared pension plan, group insurance & P.S.I. Location 25-mi. from Toronto. Apply to: The Director, Ontario County Health Unit, Pickering, Ontario.

Public Health Nurses for generalized program, salary range $3,700 - $4,500 (minimum based on experience). Good personnel policies, 3-wk. vacation, accumulative sick leave, pension plan & other benefits. Apply to: Dr. J. Howie, Director, Metropolitan Windsor Health Unit, 2090 Wyandotte Street East, Windsor, Ontario.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Assistant Head Nurses: excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Operating Room Supervisor for modern, accredited 60-bed hospital. Living accommodation available in new motel-style nurses' residence. Apply stating qualifications & salary expected to: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered Nurses & Certified Nursing Assistants for modern 60-bed General Hospital, salary $275 per mo. 5 semi-annual increases; 40-hr. wk., 4-wk. vacation. Cert. N.A. starting salary $200, 3-wk. vacation. Accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

REGISTERED NURSES

For General Duty in modern, fully equipped 22-bed hospital located in model town on north shore of Lake Superior. On C.P.R. main line and on new Trans-Canada Highway. Starting salary $335 per month with annual reviews. Subsidized room and board available in Company-operated motor hotel adjacent to hospital. 42 hour week, comprehensive benefit plan coverage and excellent recreation facilities available. Further particulars on request. State age, education, experience, Ontario registration and phone numbers in first letter to:

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Modern 900-bed hospital

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Registered Nurses for all services

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40 hour week - pension plan - good salaries and personnel policies.

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Invites application for:

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Certified Nursing Assistant Course.

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Apply to:

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GENERAL HOSPITAL,
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Registered Nurses for 30-bed General Hospital, 50-mi. from centre of Montreal, excellent bus service. Starting salary $275 per mo., 3 semi-annual increases, 40-hr. wk., 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

SASKATCHEWAN

Registered Nurses for General Duty for 24-bed hospital, a new 34-bed hospital presently under construction. Present hospital to be converted to a nursing home for the aged. Salary schedule $290-$350 gross, $10 increments every 6-mo. Living ahsommodation available in new residence. T.V. set, board & lodging $34.50 per mo., 3-wk. vacation after 1 year service. 8 statutory holidays, 1½ days sick leave accomulative up to 90-days, 40-hr. wk., bus service daily to major city. Apply to: Secretary-Manager, Union Hospital, Leader, Saskatchewan.

U.S.A.

Supervisors & Nurses for 80-bed County Hospital. Starting salary $337 - $395 plus normal increases, 3-wk. vacation. Situated in picturesque mountain foothills. No smog or rain, leisurely living-in home-like congeniality. Near Los Angeles, San Diego, Las Vegas & 8-mi from historic Mexico. Send for descriptive letter. Mr. L. J. Lonni, Imperial County Hospital, Box 1771, El Centro, California.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $350 with range to $390 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff Nurses for permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses excellent opportunities. Progressive 440-bed General Hospital, expanding to 525-beds in early 1961. Expansion is creating openings in all areas. Salary range $370 - $400 per mo., $25 P.M. & night differential. $25 additional for surgery. Liberal vacation plan, 7 paid holidays, 40 hr. wk. health insurance & retirement plan. Close to all summer & winter, mountain & ocean activities. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $345 - $415, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered General Duty Nurses (3) for small General Hospital. Starting salary $350 to $400 after 1st year. Furnished apt. available. Apply by writing: Box 336, **Dos Palos,** California, or Phone Collect Express 2-3450 after 6 p.m.

General Duty Staff Nurses for 450-bed fully approved hospital. Salary range per mo., — day duty $404-$423, P.M. & night duty — $414-$434. 40-hr. wk., excellent personnel policies. Registration or permit to work in California required. Address applications to: The Chief Nurse, Southern Pacific Hospital, San Francisco 17, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro, area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

THE SCHOOL OF NURSING, BROCKVILLE GENERAL HOSPITAL

BROCKVILLE, ONTARIO

Requires

Science Instructor

Requirements: University preparation in Nursing Education

Salary differential for degree

Progressive Policies in Progressive Surroundings.

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REQUIRES

Administrative Supervisor evening and night rotation of duty.

Administrative Supervisor for Operating Room

Instructor in Surgical Nursing

Instructor in Medical Nursing

For further information write:

THE DIRECTOR OF NURSING

PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

SUDBURY MEMORIAL HOSPITAL

REQUIRES

Supervisor — Nursing Office — day duty, responsible for in-service program for General Staff Nurses.

Supervisor — for Obstetrical Department.

Head Nurse — for Post Partum Area.

Apply:

DIRECTOR OF NURSING,

SUDBURY MEMORIAL HOSPITAL, REGENT ST. S., SUDBURY, ONTARIO.

DIRECTOR OF NURSING

Applications are invited for the position of Director of Nursing in a 66-bed accredited hospital. An opportunity for one capable of maintaining an excellent standard of nursing care with adequate and well trained staff.

Well equipped hospital beautifully situated in the Niagara peninsula — just 10 minutes from downtown Buffalo.

Apply:

SUPERINTENDENT, DOUGLAS MEMORIAL HOSPITAL,
FORT ERIE, ONTARIO.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $350 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered Nurses for expanding 424-bed General Hospital near Chicago's West Side Medical Center. Starting salary $390; $420 for P.M.'s & nights. Benefits include 8 paid holidays, up to 4-wk. vacation, sick leave, Blue Cross & pension plan. Convenient to "Loop" & super highways. Private room accommodations available. Write: Diretor of Nursing Service, Dept. C.J.N., Mount Sinai Hospital Medical Center, 2750 W. 15th. Place, Chicago 8, Illinois.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Staff Nurses General Hospital within 20 minutes of New York City. Openings on all services & shifts. Salary & benefits equal to or exceeds other hospitals in North Jersey area. Contact: Personnel Department, St. Elizabeth Hospital, 204 So. Broad Street, Elizabeth, **New Jersey.** — PHONE EL 5-3100.

Staff Nurses present 260-bed hosp. with 120 Med-Surg. beds now under construction for completion Aug. 61. Trans. pd. 1st. class air to Albuq. & return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment". Career opportunities, largest pvt. JCAH accredited hosp. in state; near U of New Mexico — R.N. & B.S.pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds. & O.R. Salaries $315 per mo. Even., Night or O.R. with call; 6-mo. increases up to $375; Days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent. P.M. or night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp., Services, pd. sick leave cumulative to 5-wks., annual physical exam., vacation 1-yr-2-wks., 2-yrs.-3-wks., 5-yrs.-4-wks. Active inservice pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Centre, 1012 Gold. S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Supervisors — Medical-Surgical, Pediatrics, Obstetrics & Psychiatric. Base salary $400 to $439, depending upon preparation & experience. Liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs. Housing available on campus or in vicinity of hospitals. Apply: Director Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

General Duty & Operating Room Nurses for 210-bed General Hospital. Start $335 days, $360 evenings, $355 nights, plus $10 for O.R., university city, 40-hr. wk., 7 holidays, extended vacations, sick leave benefits, free Blue Cross hospital-medical insurance & $2,500 life insurance, retirement program plus Social Security, extensive Intern-Resident Educational Program, living quarters available. Write, Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington.

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $280 to $320 gross per month. Differential for evening and night duty. Temporary residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL, SASKATOON, SASKATCHEWAN

THE MONTREAL GENERAL HOSPITAL

invites applications for the position of

CLASSROOM OR CLINICAL INSTRUCTOR

Please apply to:

THE DIRECTOR OF NURSING
THE MONTREAL GENERAL HOSPITAL
1650 CEDAR AVE., MONTREAL, QUE.

NURSES NEEDED IN NORTH

Registered Nurses for new modern 16-bed hospital. Starting salary $285 per month with increments for each year of experience less $35 for full maintenance. Will pay train or bus fare one way. One month vacation with pay after 1 year service.

Apply to:

BOX 250,
MANNING MUNICIPAL HOSPITAL, MANNING, ALBERTA.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $285-$335 per mo. Certified Nursing Assistants $210-$240 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

THE MONTREAL GENERAL HOSPITAL

invites applications from Registered Nurses for positions in the

OPERATING ROOM

and on a variety of

NURSING UNITS

Please apply to:

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THE MONTREAL GENERAL HOSPITAL
1650 CEDAR AVENUE
MONTREAL, QUEBEC

McKELLAR GENERAL HOSPITAL

School of Nursing

will have openings for

INSTRUCTORS

in Medicine, Surgery and Pediatrics

by July 15th, 1961

Qualified applicants are invited to apply:

Salary commensurate with experience and qualifications.

Apply to:

DIRECTOR,
McKELLAR GENERAL HOSPITAL,
FORT WILLIAM, ONTARIO.

INSTRUCTOR

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CITY HOSPITAL, SASKATOON, SASK., (330-beds)

A clinical instructor in obstetrical nursing. Salary commensurate with preparation and experience. Liberal vacation with pay, cumulative sick leave, superannuation plan.

Apply:

DIRECTOR OF NURSING, CITY HOSPITAL, SASKATOON, SASKATCHEWAN

BRITISH COLUMBIA

Emergency Operating Room Nurse with postgraduate or equivalent for a very active 32-bed modern hospital, 14-mi. south of Nanaimo, B.C. Rooms available in nurses' residence. Salary & personnel policies in accordance with RNABC. Position open May 1st. 1961. Apply stating qualifications & experience to: Director of Nursing, General Hospital, Ladysmith, British Columbia.

NOVA SCOTIA

Registered Nurse as Assistant to Head Nurse O.R. (Vacancy June 26th. 1961) postgraduate course not essential, experience necessary. Apply stating experience to: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

MANITOBA

Registered Nurses (4) for 36-bed hospital, 40-hr. wk., salary $305, increase of $5.00 every 6-mo., statutory holidays, overtime pay, good living quarters, $45 full maintenance. Apply: S. Derksen, Bethel Hospital, Winkler, Manitoba.

ONTARIO

Registered Nurses (2) (by June 1st.) for an active 50-bed General Hospital 100-mi. northwest of Toronto. Addition of 35-beds by end of year. Please apply to: Director of Nursing, Memorial Hospital, Listowel, Ontario.

Public Health Nurse (Qualified-Catholic) for St. Elizabeth Visiting Nurses' Association. Minimum salary $3,825, annual increment, 5-day wk., 4-wk. vacation. $100 uniform allowance. Pension, P.S.I., Blue Cross. Apply: Director, 67 Bond Street, Toronto 2, Ontario. EM 8-1863.

Registered Nurses, Certified Nursing Assistants for General Duty for 58-bed hospital. For full information please write to: Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

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Applications are invited for the position of Director of Nurses in fully accredited 85-bed hospital, from Registered Nurses holding degree in nursing administration or with equivalent in experience. Salary scale $5,100 - $5,700.

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KENORA, ONTARIO

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General Duty

40-hour week, excellent salary and personnel policies.

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Clinical and classroom teaching Ultra modern school and hospital buildings. Good personnel policies.

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for generalized program, Town of New Toronto, salary range $3,400 to $3,800 starting salary depending upon experience, 5 day week, pension benefits, sick leave plan, Ontario Hospital Services, P.S.I., car allowance provided. *Apply to:*

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Pleasant city of 38,000 close to larger centers

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for

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June 1, 1961

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GENERAL HOSPITAL,
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requires

GENERAL DUTY NURSES

for:

Medical, Psychiatric and Surgical Floors (male or female Registered Nurses considered for all above positions)

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REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

are needed for
a new 225 bed hospital
to be opened
February 1961

For information, write to:

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Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

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NURSES NEEDED

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Increases: After 6 months, 1 year, 2 years.
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FOR ALL DEPARTMENTS

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offers qualified Graduate Nurses a 16 weeks' course in

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The course includes instruction and supervised experience in all surgical specialties as well as teaching and management techniques.

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for Staff and Supervisory positions in various parts of Canada.

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Positions available in all Clinical Areas

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HAMILTON, ONTARIO.

(2) Medical Unit

Apply to:
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NORA-FRANCES HENDERSON HOSPITAL,
CONCESSION STREET,
HAMILTON, ONTARIO.

(3) Medical - Surgical - Pediatric Unit & Operating Room

Apply to:
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BARTON STREET EAST,
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Personnel Policies sent on request.

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(360 BEDS)

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REGISTERED NURSES WANTED

Excellent working conditions: pension plan, salary range $60 - $80 per week according to qualifications.

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HOPITAL JEAN-TALON
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MONTREAL 35

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TUBERCULOSIS DIVISION

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REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS

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Good personnel policies

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COMPETITION NO. 60:484.

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CLINICAL INSTRUCTOR

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requires

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for

OPERATING ROOM

MEDICAL
SURGICAL &
OBSTETRICAL
} DEPARTMENTS

Apply

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44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies.
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Salary — $265 - $315 per month 40-hour week, no split shifts.

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Transportation — advanced on repayable basis. For 75-bed fully accredited hospital built in 1956, located in south-western Ontario.

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Further your Nursing Experience

Opportunities open for
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Liberal personnel policies
Hospital within walking distance of
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Every effort is made to provide the opportunity for each nurse to reach her potential

Must be eligible for registration in the State of Michigan

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Transportation will be advanced if necessary.

Apply: Matron,
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for Operating Room, Surgical, Medical & Obstetrical Units.

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THE DIRECTOR OF NURSING,
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McGILL UNIVERSITY

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1266 PINE AVE. W., MONTREAL 25, QUEBEC.

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   Classes—September and February.

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   Classes following the six month course in Obstetrical Nursing.

   (c) Eight week course in Care of the Premature Infant.

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2. Six month course in Operating Room Technique and Management.

   Classes—September and March.

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   Classes—September and March.

Complete maintenance or living-out allowance is provided for the full course.

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FOR
REGISTERED NURSES
Notre Dame Hospital of Montreal

- GENERAL MEDICINE
- GENERAL SURGERY
- OPERATING ROOM
- OBSTETRICS

Classes: March and September
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Substantial remuneration
Meals and laundry provided.
Ability to speak French essential.

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LA DIRECTRICE DU NURSING
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- As well as two other eight-month postgraduate courses in:
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- Obstetrics.

Admission in October.
Ability to speak French essential.

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HOPITAL SAINTE-JUSTINE
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Offers to qualified Registered Nurses a 16-week supplementary course in

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- REGISTRATION FEE IS $20
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For information write to:

Director of Nurses,
Wills Eye Hospital,
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ADVANCED OPERATING ROOM TECHNIQUE AND MANAGEMENT

is offered by

THE MONTREAL GENERAL HOSPITAL

to

Qualified registered nurses. Classes of 6 months' duration are admitted *September* and *March* and are limited to 6 students.

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THE DIRECTOR OF NURSING,
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MONTREAL 25, QUE.

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Qualifications: University preparation in teaching and supervision is necessary with several years experience in a supervisory position. Fluency in the French Language is desirable but not necessary.

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Director, Extension Course in Nursing Unit Administration,

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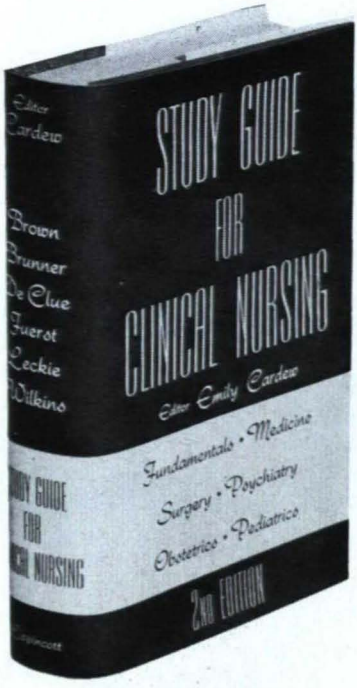

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Editor: EMILY C. CARDEW, R.N., M.S. *Fundamentals of Nursing* by ELINOR V. FUERST, R.N., M.A.; *Nursing Care of Adults with Medical and Surgical Disorders* by LILIAN SHOLTIS BRUNNER, R.N., M.S. and IRENE LECKIE, R.N., B.S.; *Nursing in Obstetrics and of the Newborn* by JAYNE DeCLUE, R.N., B.S.; *Nursing Care of Children* by GLADYS WILKINS BONINE, R.N., M.A.; *Nursing of Psychiatric Patients* by MARTHA M. BROWN, R.N., M.A. About 563 Pages. New 2nd Edition, March 1961. $6.50.

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